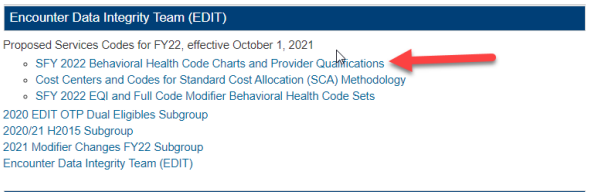
FY22 Code Set Question/Answer Document
Technical Assistance
July 27, 2021 (12/15/2021)

Question	Answer
Why are certain modifiers not included in the code sets? For example, H2015 does not have an overnight modifier (UJ)	For clarity, we have created both an EQI code set list and a Full code set list. The EQI code set list previously reviewed did not included Program modifiers that are not anticipated to impact costing, consistent with feedback received from the EDIT modifier subgroup. Based on additional review and discussion, the UJ modifier was added as a Method modifier and will be included in the SFY 2022 EQI code set list.
Why are many modifiers and codes present in the 2021 code sets but not present in the 2022 code sets?	Please see response to question above regarding clarity on the EQI code set list. The Changes From 21 to 22 Code Sets provides a list of all changes made. Modifiers that were determined unnecessary or where the information gained from the modifier was able to be captured elsewhere (such as BHTEDS or diagnosis codes) have been removed. This includes HF for SUD and U5 for Autism.
H0039 and H0039 Y4 are the only modifier combinations listed for ACT. It's indicated in the 'Team Based Service' row of this tab "Team-based Service - no provider modifiers". But on the Modifiers Code Lists tab, H0039 comes up in all the provider level modifiers, examples HN, HO, HP, SA, etc.. Does this mean it's optional to report provider level modifiers for ACT?	The EDIT modifier subgroup feedback suggested that the EQI code set reporting be limited to those that impact costing. In general, team-based services do not require provider group modifiers as they do not impact costing. However, MDHHS would like to retain provider group modifiers on the encounter reporting for monitoring purposes for ACT services. Similarly, they would also like to retain the UN-US modifiers for group size for ACT.
Under the U7 Modifier should Supported Employment, Supports Coordination, PT, OT services be added or some direction that U7 isn't needed on all services that are self determined?	A note has been included on the Modifiers tab that U7 can be added to any code that is a self-directed service. We have included the U7 modifier in the Code Charts tab for all services that U7 is anticipated to be common.
What qualifications are allowed to use H0031 in the new qualified providers in SFY 2022?	The qualified providers for H0031 is narrowed in SFY22 to the following providers: • Therapeutic Recreation Specialist (HN) • Educator with a degree in education (HN) • HR professional with a BA • Behavior analyst Other providers previously qualified to provide H0031 can use other assessment codes appropriate to the service provided, as shown in the H0031 Crosswalk tab of this workbook.

Question	Answer
	A separate row exists in the Code Chart tab for H0031/WY, which is used for reporting SIS assessments face-to-face with consumer. Qualified providers for H0031/WY are: • Bachelor's degree in Human Services (HN) • Four years of equivalent work experience in a related field (HM) A separate row exists in the Code Chart tab for H0031/WX, which is used for reporting LOCUS assessments. Qualified providers for H0031/WX are: • Bachelor's degree in Human Services (HN) • Master's degree in Human Services (HO)
What is code T1040?	This procedure code is an indicator for CCBHC services and should be included as an additional claim line on all CCBHC encounters.
I notice in the definition for T1017 it does not include Supports Coordinator Broker. Will a Broker be allowed in the future?	The description will be modified to include "Case Management and Supports Coordination" as well as including the Supports Coordinator Assistant and/or Broker in the provider qualifications. Provider group modifiers will distinguish between the Supports Coordinator Assistant and/or Broker from the Supports Coordinator and Case Manager. There is not clear distinction across the state regarding definitions for Case Management and Supports Coordinator and MDHHS no longer is requiring separate identification.
The Final 2022 Code Sets list includes modifier 1Y-5Y for Supported Employment. Weren't those modifiers implementations deferred to SFY 2023?	The definitions for level of specificity that MDHHS wants have not been fully developed, discussed, and implemented into the Medicaid Provider Manual (MPM), including language surrounding groups and enclaves. MDHHS is delaying the implementation of these modifiers and H2025 to SFY 2023 to support further work on this service. SFY 2022 code sets will include the UN-US group modifiers for H2023 instead of the TT modifier.
Is the new Job Coaching (H2025) service applicable for groups, or is this intended to only be a one-on-one service?	Its intent is a “one-on-one” purpose only. However, H2025 implementation is delayed until SFY 2023
Which of the two modifiers should be used for a psychiatrist – AF (specialty physician) or AG (physician)? And what defines a "Specialty Physician?" Any information would be very helpful.	The difference between the two would be that a “specialty physician” would specialize/be an expert in a field, such as psychiatry/cardiac/OBGYN/etc., whereas a “physician” would be a general practitioner, such as a primary care doctor. A psychiatrist would fall under the specialty physician modifier.

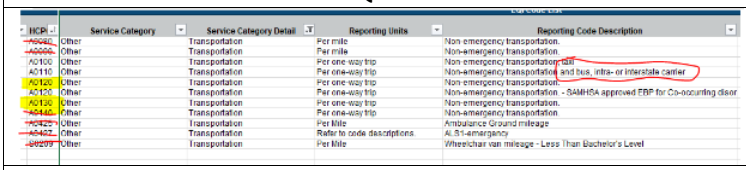
Question	Answer
Will you confirm that the TG modifier on the H2023 is going away for FY 22 as it relates to our supported employment services provided thru a MDHHS certified EBP? Shouldn't the TG be in the notes section as a prior modifier?	Y5 replaced the TG for H2023 effective 10/1/21.
Does the 'Modifier Prioritization' as written in the attached SFY 2022 Code Sets document still apply and considered final? We heard this may change to alphabetical order and just want to be sure we have the most current info.	The Modifier Prioritization will not be changing to alphabetical order. Modifier prioritization is not required on the encounter data but will be required in the EQI template reporting.
Are the '1Y-5Y' modifiers for Supported Employment finalized for 10/1/21? They do not appear on the 'Final 2022 List' tab of the attached worksheet and unsure if they are still pending.	The 1Y-5Y modifiers for supported employment have been delayed until SFY 2023.
What code are master's level clinicians supposed to use now when doing an intake assessment or annual assessment for our consumers? They have always used the H0031, and upon quick review of the H0031 crosswalk, it didn't appear that any of those other assessments that LPCs or LMSW/LLMSW can provide fit the definition for an intake or annual mental health assessment. Follow-up Question: I don't think that any of those codes seems to match the intake assessments that are done. I guess as a follow up to this question when it is discussed at the TA training, can they maybe further review exactly what 96110 is to see if that would cover the general intake assessment to see if they qualify for services, and is this only for children? What would be used for adults? 90791/90792 would not be appropriate to use as our psychiatrists use that code when they do psych evals. 96112/96113 doesn't seem appropriate either for the general intake assessment.	Please refer to the H0031 crosswalk tab in the SFY 2022 Behavioral Health Code Charts and Provider Qualifications workbook for possible options. Other suggested LMSW options include: 96110, 96112, 96113, 90791-90792. The code chart document can be found on our website: MDHHS - Reporting Requirements (michigan.gov) >> scroll down and click on Encounter Data Integrity Team (EDIT) and select the second bullet "SFY 2022 Behavioral Health Code Charts and Provider Qualifications."  Follow-up Answer: The 90791 should be used by the staff that do not prescribe and the 90792 should be used by the prescribing staff. The 90791 is generally used by Master's level staff for biopsychosocial assessments.
Currently H0031 is being used for the Mental Health Initial Assessment / BPS and the annual BPS. The Initial is completed by a Master Level (LMSW) because the LBSW is not able to diagnose. The Annual is sometimes completed by a bachelor's level as the diagnosis is already assigned by other professionals through IPOS/IPOS Updates. The below is being interpreted to mean that only a clinician of a bachelor's or less can use the CPT H0031. If that is the intent, we will struggle to find an appropriate assessment code for the Initial and Annual BPS for professional providers. Were there suggested assessment codes offered by the modifier workgroup that LMSW's could use? Is it being suggested that H0002 code be used?	Please refer to the H0031 crosswalk tab in the SFY 2022 Behavioral Health Code Charts and Provider Qualifications workbook for possible options. Other suggested LMSW options include: 96110, 96112, 96113, 90791.

Question	Answer
We have a couple Psychologists that are limited license so when including the credential modifier would we use the HO?	Yes, use the HO and we have added this to H2000.
For ABA services if a Behavioral Technician has a bachelor's degree what credential modifier are you looking for as the HN is listed for the BCBA?	~~There is not a modifier requirement for Behavioral Technicians.~~ 9/10/21 update: the HM to reflect the BT should be used on 97153, 97154, and 0373T. 9/13/21 update for clarity: BCBA requires a master's degree which is the HO modifier not HN.
Can we implement the FY22 Modifier changes as a "rolling implementation" over the next twelve months, with completion of the implementation by 10-01-2022, instead of a "hard implementation" where all IPOSs, Authorizations and Claims must be converted to the new modifiers on 10-01-21?	Authorizations and Claims but must be converted to use the new modifiers effective 10/1/21.
Can MDHHS add the master's level and Doctoral level modifiers back to H0031? The rationale for this request is that there are several assessments that can be performed by either bachelor's or master's level staff. If MDHHS does not add back the Master's/Doctoral modifiers, then we will have to report two different codes for the same assessment tool—one for the bachelor's level staff and one for the Master's/Doctoral level staff. Note: the outcome of an assessment does not vary based upon the provider's education-level; we recommend that all education-level modifiers be allowed on H0031. The cost of an assessment does vary based upon the amount of time the assessment takes: LOCUS assessments are quick, whether staff has a bachelor's or Ph.D., and that pays a lower rate than a Biopsychosocial which takes a long time, whether staff has a Bachelor's or Ph.D. LOCUS assessment can be performed by either Bachelor's level staff or Master's level staff. The initial Biopsychosocial assessments are usually performed by Master's level staff, due to the diagnostic array. Whereas the annual biopsychosocial assessments are often performed by Bachelor's level staff.	There will not be two codes. H0031 is the only code. LOCUS -- use HN for bachelor's and higher degrees. Additionally, add the WX to show that it is LOCUS. SIS - use HN for bachelor's and higher degrees. You can track locally the staff level with an internal method; however, the Department will not be tracking on this. Additionally, add the WY modifier to show that it is SIS.
Can MDHHS keep the AH, AJ and HP modifiers in place for H0031 for the Autism Eligibility Assessment? DWIHN currently uses H0031 to complete eligibility evaluations for the Autism Spectrum Disorder Benefit. Typically, this consists of an ADOS-2 and an ADI-R among other things, however, since the ADOS-2 is not standardized with PPE/telehealth MDHHS has indicated that a combination of parent interview, history review and behavior assessment instead of an ADOS-2. We have reviewed the MDHHS "H0031 Crosswalk of options for assessment codes by provider type" and DWIHN is having a	MDHHS recommend the use of the 96116. We will add the 96116 to the H0031 Crosswalk and update the provider qualifications to allow for Physicians, MSWs, Psychologists, Professional counselors and Marriage and Family Therapists. 9/10/21 Update: Lyndia Deromedi pointed us to some research that was done as to what codes best reflect the ABA assessments. DBPCodingUpdate2019final.pdf (washington.edu)

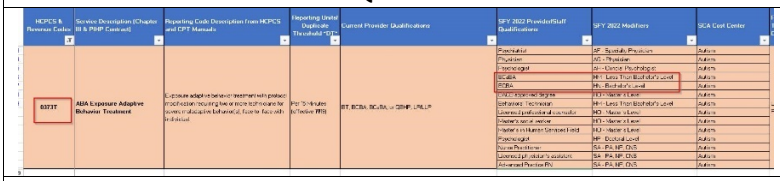
Question	Answer
difficult time finding an alternative code to cover this service, as it might involve administration and scoring of psychological measures, or it may not, given the issues with standardization with PPE/Telehealth. The clinicians completing this are either master's level or PhD level clinicians. Is it possible to keep modifiers AH (clinical psychologist), AJ (clinical social worker), HP (doctoral level psychologist) in place for the ASD Benefit? If not, does MDHHS have a specific code that they want DWIHN to utilize to authorize this service?	According to this document it states that while the 96116 works, the better two codes to use for ADOS testing are 96112 and 96113.
Occupational Therapy and Physical Therapy assessments and services can only be provided by "HN – Bachelor's degree" staff or OT/PT Assistants. Sometimes our OT/PT staff have master's degrees. Can MDHHS add the modifier "HO – Master's degree, Other" back to the OT/PT codes?	The HO is available in the Behavioral Health Code Charts and Provider Qualifications workbook. I also see that the HO is available on the EQI Code List.
Our clinicians have raised another question about the Psychotherapy service array: 90832, 90834 and 90837. These codes require the Education-level modifier in Mod_1 and either Y4 (Co-occurring EBP) or ST (Trauma) in Mod_2. However, our clinicians question what to do if a member with cooccurring disorders needs psychotherapy for a trauma related issue. Do they have to decide between Y4 and ST, or can we report all three modifiers: Education-level + Y4 + ST? Currently the MDHHS excel file does not include rows for 90832, 90834 and 90837 with all three modifiers listed. Please advise on how we should approach this?	We will update the list to reflect the code and modifier options.
Does MDHHS plan to restore the H0043 CLS per diem code?	There are no plans currently to restore the H0043 per diem code.
If staff are doing an hour HB service and they spend 30 minutes with the client & mom; and then spend 30 minutes with mom only, do you expect to see 2 encounters? One with the HS (client not seen) modifier and one without? One H0036 for 2 units One H0036 HS for 2 units Or is the HS modifier only to be used when there is a HB service where client was not present at all? Example: HB contact with mom only for 1 hr. = H0036 HS for 4 units.	Home based is a bundled rate provided to the child, parent and/or family. If it is a session that includes both the child and the parent (for the majority of the consecutive session then only one encounter and progress note are needed. If the entire session is without the client and only with the parent use HS modifier.
H0001 - Substance Use Disorder: Individual Assessment – the threshold was changed from 1/day to 4/year. If this intended to be by "provider"? There are individuals that present multiple times throughout the year for an assessment and may have more than 4 times per year. Is this calendar or fiscal year?	This is fiscal year and PIHP based, not by provider. The PIHP can support the expense 4x per FY.

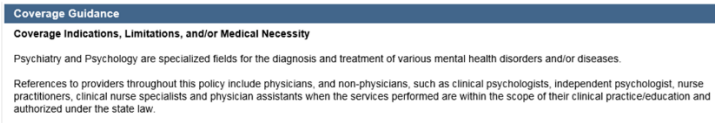
Question	Answer
Modifier AH – Licensed Psychologist – PhD, Is this the same as Modifier HP – Behavioral Health Professional PhD? If so, should they have the same modifier?	The HP modifier is for PhD level of education, so it is appropriate for any provider holding this credential.
Modifier HN – Occupational Therapist, should this include master's degree?	The HN is already included in the Code Charts tab, MDHHS will update the Job Title-Modifier Crosswalk tab to include the HN for the Occupational Therapist.
Certified Criminal Justice Professional Reciprocal is the same as Modifier HO Certified Criminal Justice Professional Reciprocal. Should the HN include bachelor's degree and HO include master's degree?	The HN, bachelor's degree, for Certified Criminal Justice Professional Reciprocal is already included on the Job Title-Modifier Crosswalk. MDHHS will update the Job Title-Modifier Crosswalk tab to include the HO, master's degree, for the Criminal Justice Professional.
Modifier HO – Physical Therapist, should this include doctoral degree?	The code chart and Job Title-Modifier Crosswalk have been updated to include the HP modifier for DPT.
McBAP Certification and Certified Clinical Supervisor, should this include master's degree?	The HO, master's degree, for the McBAP is already included on the Job Title-Modifier Crosswalk.
Development Plan Supervisor, should this include master's degree?	The HO, master's degree, for the Development Plan Supervisor is already included on the Job Title-Modifier Crosswalk.
Mental Health Clinician, should this include master's degree?	The HO, master's degree, for the Mental Health Clinician is already included on the Job Title-Modifier Crosswalk.
CCPD – Master's, can you clarify what CCPD is?	This is likely referencing CCDP, which is a Certified Co-Occurring Disorders Professional. Perhaps the person has an earlier version that may have had a typo.
Modifier WR – Peer Recovery Coach – Should this broken out by the certification completed for SUD Recovery Coaches, such as a modifier for those that have completed the MDHHS training vs. those that completed CCAR/Other training. Those with the MDHHS certification bill for the H0038 Substance Use Disorder: Recovery Support Services service code and the others bill the	The modifiers are not intended for this level of granularity. Peer Recovery Coaches all would use the WR modifier.

Question	Answer
T1012 Substance Use Disorder: Recovery Support Services service code. Would the MDHHS bill with the WR modifier and the other use the WS modifier? Can you provide guidance for the new group size modifiers (moving from the TT modifier), is the modifier established when creating the group or the number participating in each group session? If the latter, do you count participants at the beginning or the end of the session? There are times when individuals attend late or leave early or both. Is there a "minute" threshold that is considered to have attended enough to count as fully participated? If so, what is the minute threshold for a 60/90 minute group attendance?	For determining the number, use the number that attended the majority of the session and would be eligible for a billable service. This modifier does not change the current billing standards for generating a service encounter.
What is the definition of job coaching for the new H2025 code? We have many different definitions of job coaching and would like to know when to use the new code. • Job Coaching with new person = time limited. Person learns the job, coach fades off • Job Coaching – long term supports = ~~coach is needed in an Enclave setting.~~ One-on-One. Guidance and direction ~~will always be needed.~~ expected long term. • Job Coaching – follow along support = individual is secure in job placement. Job Coach will complete face to face with individual on a limited basis,(i.e. once/month) to make sure all is going well.	H2025 is applicable for Individual Competitive Integrated Employment (ICIE) only. This code implementation has been delayed to 10/1/2022.
During the Milliman presentation today for the SCA model, transportation codes were discussed. I know that there are codes that are expiring as of 9/30 and I have researched what codes are available to us as of 10/1/20. None of the per mile codes sound like they would encompass our situation. Our providers are using their own home vans and some staff in self determined arrangements are probably using their own personal vehicle. I looked in the HCPCs book for expanded descriptions. We do have vocational providers that bill us for certain consumers that they provide transportation for that appears could fall in the A0120 since they bill us per day and we could get them probably to bill us per trip. Since we had been told to bundle the costs years ago, we went to having the providers bill us using an indirect code and we would allocate that cost back to the service that it related to. We couldn't get on board with everyone bundling that cost and having a consistent rate that is why we chose to do it this way. We are now aligned for FY 23 to make the transportation change, but when Jeremy said we had codes available and that some providers were going to pilot for FY 22, I decided to see what we were looking at for change and I just don't see a code per mile that will work for our situation.	The best code for the question is A0090 (non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest. The other option is A0080 is for non-vested interest parties, e.g. volunteers, but it is possible that staff could be considered as having a vested interest. Additionally, the S0215 per mile code is also available.

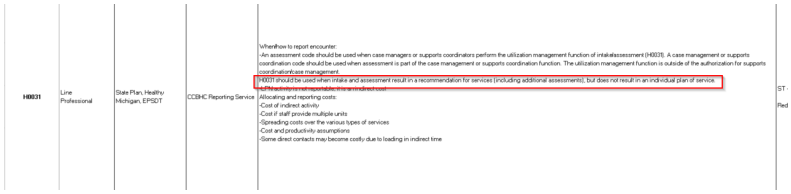
Question	Answer
	
T1016 allowed a paraprofessional to provide the service as a case manager assistant. Did that service move to another code/modifier, are those staff able to use T1017 without a BA degree, or are you eliminating the case management assistant altogether?	The supports coordinator assistant is available for T1017.
CM – T1017 was never allowed to have "assistants" provide services where SC could use "assistants". Is this changing in FY 22 where both CM & SC can use "assistants"?	Yes, both CM and SC can use assistants starting in FY22.
Modifier question: we conduct the LOCUS as part of our H0031 assessment. How would you suggest we break out coding and modifier use WX for LOCUS if it is part of our full psychosocial assessment?	~~You will need to break out the LOCUS from the assessment so would be reporting two encounters. One for the LOCUS and one for the assessment.~~ You would report one encounter with the WX modifier to indicate the LOCUS was performed as part of the assessment.
When counting persons for using the correct U modifier, in Home Based services, do you count just open consumers, or family members/others present?	Only open consumers should be counted.
For the T1017 change (elimination of T1016) will there be differences between the waiver and state plan with different requirements and separate funding or if it is all getting merged under the state plan.	T1017 is a state plan service, therefore the funding is coming from Medicaid State Plan, Healthy MI plan, and EPSDT.
I don't see H2025 in the code set.	H2025 will not be implemented until SFY2023.
I do have another question now, related to DBT and the Y2 modifier. It looks like the Y2 modifier appears with several codes in the 'Modifiers Notes with Impact to Costs' column on the Code Chart such as 90832-90837, 90847, 90849, 90853, H0036 and S5111, which are all therapy modes, except S5111, parent/family training. But there is also the DBT specific code H2019 which does indicate that it is to be used by staff certified in DBT by MDHHS. This is a bit confusing. We currently report any DBT therapy service rendered by trained staff regardless of modality (i.e. induvial therapy, family therapy, group therapy, etc.) or age of the patient, using the H2019 code rather than the other CPT codes for therapy. Should we be using the standard CPT codes and the Y2 modifier for DBT rendered to adolescents or is H2019 Y2 acceptable? Are DBT services ever allowed to be rendered by staff not certified and trained by MDHHS and that type of staff would use the standard therapy codes rather than H2019? H2019 does have the Y2 modifier available for use.	MDHHS requests that the Y2 modifier reported on DBT for Adolescents. This will need to be reported on 90832-90837, 90847, 90849, 90853, H0036 and S5111 service codes. We will take the Y2 off the H2019 since that is a standalone adult DBT service.
I noticed that the "TV" modifier for "Holiday Rate" in the Children's Waiver and SED Waiver programs does not appear on the Proposed Modifiers tab nor on the Code Charts tab. Has it	This modifier was discontinued when the SEDW and CWP changed from FFS to managed care because a year end cost settlement is no longer

Question	Answer
been discontinued, or should we keep it? If it has been discontinued, do we still have to pay a "Holiday Rate" for these services?	required. If the CMH still wants to use it locally that's fine, but we don't need it reported to MDHHS.
H0031 Crosswalk: I total understand why a license person should be using a CPT code if they are performing services such as: nutrition therapy, PT, OT, Speech, and services within their disciplines. I am confused when you get to the 90791 and 90792. Are you no longer requiring the "assessment"? Will all the paperwork required by the PIHP assessments go away? Will the providers now be able to do a 90791/90792 when they feel its medically necessary. Or is it true you expect the same questions and all the requirements of a H0031 to be billed as a 90791/90792 just based on discipline. Currently all the paperwork required by the PIHP is way more than a 90791 and/or 90792. These codes have requirements and if there are more requirements (like there currently are) you cannot call it a diagnostic evaluation. What is required in the PIHP/State of Michigan "Assessment" H0031 is above and beyond these AMA CPT code descriptions. Please correct me where I am wrong. This is a big issue as some PIHP want you to cross walk H0001, H0002 and H0031 all to a 90791/90792 and no way are they the same.	The use of other assessment codes by provider type instead of H0031 does not change or remove any current requirements for PIHP assessments. There are several assessment codes recommended on the crosswalk, depending on the scope of the service. There is not a crosswalk for H0001 or H0002. Update: MDHHS added H0002 to the H0031 Crosswalk. This provides an additional replacement code.
Can you clarify if the following modifiers will continue for SUD services? HA - services provided to adolescents HD - Women's Specialty Services (WSS) TF - Enhanced Women's Specialty Services (EWSS) Staff are working on Provider contracts, and we want to ensure we haven't overlooked any changes for SUD services.	HD will remain for SFY22. HA and TF are both discontinued effective SFY22.
Should the U-modifiers be used for H0005 for consistent reporting for group based services? Does the HS modifier need to be attached to 90846? The CPT definition of the code is without client present. If so, should the HS modifier be removed from 90847 with the expectation that 90846 be used instead?	The U modifiers for H0005 have been added. We removed the HS modifier from 90846 and 9047 since the service name states whether or not the patient is present.
On the new code chart for next FY there is an error on 0373T Modifier column. I think the first one should be HM and the 2nd one should be HO:	There was an error and MDHHS has updated to the Code Sets tab so that the 0373T shows the correct Master's level modifier for the BCBA.

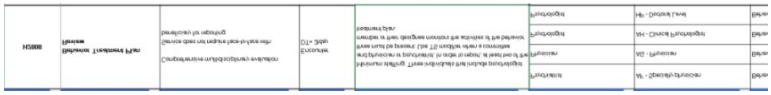
Question	Answer
	
Supports Coordination T1016 has historically been a requirement for HAB Waiver clients. With T1016 Supports Coordination expiring on 09/30/2021, and converting into T1017 Case Management, what does this mean for the HAB Waiver clients require of supports coordination? Is that no longer a requirement?	The coding change does not impact the HSW requirements.
Regarding the case management code that is coming on October 1, are we still required to have a staff to provide the case management and also have the Targeted Case Management modifier- or will all case management under that code be sufficient? The reason I ask is because we are having one heck of a time getting individuals who qualify for the targeted case management role, but if that will no longer be required, this might free some things up for us.	The provider qualifications are still required per the approved state plan amendment policy as written.
It appears that the therapy codes (i.e. 90832, 90834, 90837) include modifiers that are not qualified to provide the service based on the current provider qualifications, such as bachelor's level and lower. Would it be possible to add back T2003 for gas cards? For SUD services, this code is sometimes used to provide a gas card to assist with transportation costs for individuals to attend treatment. Code S0215 would require payment directly to the consumer which is not allowed.	The chart is correct since the CMHP allows for the bachelor level for children's services. Updated the SUD Therapy lines to delete the bachelor's level and lower providers as well. T2003 has been added back.
What is HR professional in the code sheet in reference to provider qualifications for H0031? To me HR is Human Resources so that can't be right. Should this be HS for Human Services bachelor's degree? The ability for a bachelor's level social worker to perform these assessments seems to have been removed even though they are QMHP. I'm wondering if that was intentional or if this HR is the issue?	This is an error. It would Human Services Degree as the QIDP allows that option. The charts will be updated.
I have another question about education-level modifiers. If a Pharmacist (Doctor of Pharmacy) provides an assessment and a treatment plan as part of our Med Drop program, which codes should we use and which education-level modifier should we use? Please help. We previously reported H0031 and H0032 for the assessment and treatment plan, respectively. Although we have the "HP" modifier for "Doctoral level", Pharmacist is not listed as a job description for HP.	The PIHP/CMHSP Provider Qualifications list only two codes specifically for a Pharmacist (H2010 and H0020). H0032 does list the HP modifier for "psychologist" which is for a PhD level position but can also be used for the PhD Pharmacist. For H0031, please see the cross walk. Any codes with "psychologist" listed is able to use the HP modifier.

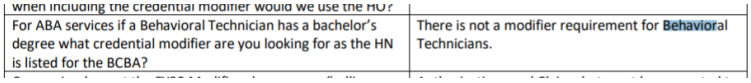
Question	Answer
In conversations about the H0031 assessment changes for FY 22, it was brought to my attention if we have our LMSW use a 90791 for our intake as opposed to the H0031 that we currently use and the consumer has Medicare and we ultimately bill for that – then suppose the consumer is authorized for psych services, our prescriber could not code a 90792 for the psych eval to begin services we could not then bill Medicare because of how we coded the intake. Any suggestions? Additionally, we didn't find where we could bill Medicare for non-physician's practitioners except for:  **Coverage Guidance** **Coverage Indications, Limitations, and/or Medical Necessity** Psychiatry and Psychology are specialized fields for the diagnosis and treatment of various mental health disorders and/or diseases. References to providers throughout this policy include physicians, and non-physicians, such as clinical psychologists, independent psychologist, nurse practitioners, clinical nurse specialists and physician assistants when the services performed are within the scope of their clinical practice/education and authorized under the state law. Do you have documentation that we can use LMSW, LPC and marriage counselors for a psych eval for dual eligible?	MDHHS asked for additional details as to why the 90792 would be unavailable and the response was that: the psychiatrist would bill using the psych eval code 90791 or 90792 – you can't bill a 90791 for the assessment then turn around and bill another psych eval with med review 90792 a couple of weeks later. Medicare allows for one psych eval for one episode or if there is a change in the situation that would warrant another eval. Our recommendation is to use the crosswalk to find an alternative code then if the 90791 won't work. MDHSS only has information pertaining to the allowable providers for Medicaid covered services. Per CHAMPS, the allowable providers to bill for 90791 are: Physicians, Psychiatrists, Clinical Nurse Specialist, Licensed and limited-licensed Psychologists, Marriage and Family Therapists, Nurse Practitioners, Physician Assistants, Professional Counselors, and Master level Social Worker's.
Instead of having to use the A0120/A0130 and determine the mode of transportation (bus vs wheelchair van) could we not just use T2003 and enter one encounter for the day with the total charge? I dislike that the HCPC book is so vague – any suggestions?	We agree that T2003 can be used.
Also, we provide bus tickets to some of our consumers. Could we use the A0120 code for those situations? What if we provide a transportation booklet which allows for multiple trips but we might not know when they take those trips. Could we enter on one day into our claim system a service equal to the number of trips that booklet allows or do you have another suggestion for us to be able to record that expense with a reportable encounter?	Use T2003 for bus tickets/token/gas cards. Bus tickets are like gas cards in that they both are pre-paying up front for travel that will occur as the funds or tickets are drawn down/used.
1. 90834 does not allow for the ST modifier – is that intentional? 2. 90832: has been assigned the Y1 modifier for Prolonged Exposure Therapy, but Prolonged Exposure Therapy is expected to be 90 minutes in duration (there are times it may not be exactly 90, but it should be 90837 not 90832. 3. Autism will now be captured through diagnosis codes and BH-Teds. This should be updated for diagnosis only as Teds does not have a field for Autism	1. We will add the ST to 90834. 2. We will remove the Y1 from the 90832 and add to the 90837 to reflect the higher time.
1. For 90839 and 90840 the only evidence based practice modifier listed is Y4, no Y1, Y2, Y3. This might make sense based on that it's 'psychotherapy for crisis' but wanted to double check. And should 90839 and 90840 have the ST modifier?	1. We will add Y1, Y2, and Y3 for 90839 and 90840. We will add ST to 90839.

Question	Answer
2. On the "Code Chart" tab, 90832 has ST, Y1, Y2, and Y4 listed, but 90834 only as Y4, 90837 only has ST, Y2, and Y4, and 90839 only has Y4? Seems all should have what 90832 has. Is this correct? 3. Also 90792 for MH coverage has Y4 listed but 90791 does not? But seems both these services could be rendered as "SAMHSA approved EBP for Co-Occurring disorders? Is this correct?	2. We will update the "Code Chart" to ensure 90837, and 90839 have ST, Y1, Y2, Y3, and Y4 modifiers listed. 90832 will have ST, Y2, Y3, and Y4. 3. We will add the ST modifier for 90792. We will add Y4 to 90791.
With all of the changes coming to the H0031, I am hoping you can help clarify what code should be used to complete an Intake? Would we continue to use the H0031? The 90791 will not work for many of our individuals as they have Medicare. Medicare requires that 9 codes to be provided in a clinic setting and many of these individuals must be seen in their own homes. Any direction you could provide would be greatly appreciated. The H0002 is a brief screening which is used for the initial call when access to services are being requested. The actual intake assessment is much more in depth. The intake assessment is typically scheduled at the time of the brief screening and often times is completed in the individuals home. Are there any other suggestions on codes that could be used? In addition, to the above, I have another question in regards to screenings for codes such as: 96110, 96112, and 96113. Is there a list of approved screenings that can be used? One in particular we found was the Columbia Suicide Screen. The GAD-7 and PHQ-9 are not necessarily designed for the DD population and do not allow for a proxy to help in answering the questions. If you have a list of screenings that could help, it would be greatly appreciated.	Please see the H0031 crosswalk. H0031 will be limited in use in FY22 (please see code chart for qualifications). Please see the H0031 crosswalk. H0031 will be limited in use in FY22 (please see code chart for qualifications). The general descriptions of the codes should guide the selection of the appropriate code for the assessment. Some assessment tools may be locally used, but not specified in the code description.
Is it possible to add the HO (master's level) to the SIS Assessment (H0031 WY) on both this and the EQI charts? If not, should we just use the Bachelor's modifier for our Master's level person that does ours?	No, just use the bachelor's level modifier for bachelor's and higher providers.
The H0031 code is to be used for the LOCUS and SIS assessments, but the CAFAS, PECFAS, and DECA assessments (all for children) were not included to use the H0031. 1. As the CAFAS, PECFAS, and DECA are all assessment tools for children (each one based on the child's age) to assist in determining the appropriate Level of Care, similar to the LOCUS for SMI adults, should the H0031 be used for the CAFAS, PECFAS, DECA assessments?	WX with H0031 is used for the LOCUS WY with H0031 is used for the SIS The CALOCUS is not recognized in Michigan and would not require a modifier. The state would not expect encounters to reflect use of this tool. CAFAS, PECFAS, and DECA - Please see the H0031 crosswalk. 96110-96113 identify use of these codes for these assessments.

Question	Answer
2. The CALOCUS tool is also used for children. Should the H0031 code be used for the CALOCUS (or is the H0031 only used with adults receiving a LOCUS assessment)? 3. If no, please provide clarification on code you use for these children's assessment tools?	
Could I please get a little more clarification on this? Is this saying that if we do an intake assessment and recommend the client for services and the client cancels or never shows up (or moves out of county, etc.) and an IPOS is never done, we should bill that assessment as an H0031? If so, I'm not sure how feasible that will be. It might be months later and we would have already billed the 90791 and reported it. Is it also saying we should use the H0031 (instead of 90791) if we do the intake assessment and client does not qualify for services so an IPOS will not be done?  H0031 | Line Professional | State Plan, Healthy Michigan, EPSDT | CCBHC Reporting Service When/how to report encounter: -An assessment code should be used when case managers or supports coordinators perform the utilization management function of intake/assessment (H0031). A case management or supports coordination code should be used when assessment is part of the case management or supports coordination function. The utilization management function is outside of the authorization for supports coordination/case management. -H0031 should be used when intake and assessment result in a recommendation for services (including additional assessments), but does not result in an individual plan of service. ~~Staff time by non-responsible financial practices~~ Allocating and reporting costs: -Cost of indirect activity -Cost if staff provide multiple units -Spreading costs over the various types of services -Cost and productivity assumptions -Some direct contacts may become costly due to loading in indirect time ST Red	There is an EDIT subgroup that will be going through that specific column to update and remove outdated language.
I feel like we have had this discussion before, but please review my logic below and confirm that I am correct. We hired a staff in a case management role. They have a Master's in Education (school counseling), but a Bachelor's in psychology. When I look at the Master's level modifier below none of the provider qualifications fit so I assume that we would enter that staff degree for that position as Bachelors and use the HN modifier – do you agree? Could we use a blanket statement that we use the highest level of degree that the staff has related to the services that they will be providing? HCPCS & Revenue Codes: T1017 Current Provider Qualifications: QIDP or QMHP: if case manager has only bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QIDP. Services must be provided by a CMHP or is supervised by a CMHP while the individual is working towards becoming a CMHP to any child beneficiary with SED. Services to children ages 7 through 17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4 through 6 with SED must be provided by a CMHP trained in PECFAS. Services rendered to a young child, birth through age 3, must be provided by a CMHP trained in the Devereux Early Childhood Assessment (DECA) SFY 2022 Provider/Staff Qualifications / SFY 2022 Modifiers: Educator with a degree in education — HN - Bachelor's Level Behavior analyst — HN - Bachelor's Level Therapeutic recreation specialist — HN - Bachelor's Level Physical Therapist — HN - Bachelor's Level Occupational Therapist — HN - Bachelor's Level HS professional with BA — HN - Bachelor's Level Registered Dietician — HN - Bachelor's Level Speech-language pathologist — HO - Master's level Audiologist — HO - Master's level Master's social work — HO - Master's level Licensed professional counselor — HO - Master's level Marriage and family therapist — HO - Master's level Psychologist — HP - Doctoral Level Licensed physician's assistant — SA - PA, NP, CNS Independent Facilitator — WQ - Independent Facilitator Supports Coordinator — HN - Bachelor's Level Supports Coordinator Assistant — HM - Less than Bachelor's Level Broker — HM - Less than Bachelor's Level Registered nurse — TD - Registered Nurse	MDHHS agrees with adding the highest degree level allowable such as in this case the bachelor's since master's did not fit. Not every provider level of education/degree can possibly be listed.
For further clarification related to reporting the LOCUS, CAFAS, DECA. We currently complete these assessments during another service, such as an Intake, Annual, Periodic Review, so we have	Current practice is to count one encounter, so an additional encounter would not be appropriate. The intake would include all

Question	Answer
been reporting it under that service, which could be an H0031, T1016, T1017 based on which service they were providing. Would you now be expecting that same service still to be reported and then another encounter for the LOCUS, CAFAS, Deca? For Example, we would report the following for the same person and same service date: H0031 - No Modifier for the annual assessment H0031 - WX or 96127 based on which assessment is completed (LOCUS, CAFAS etc.) We want to be sure that we are not reporting two encounters when we should only be reporting one.	activities in the encounter. Additionally, an original call to gather initial information would not be considered an encounter.
Currently, at MCCMH, the 'LOCUS' assessment is rendered and integrated into the Intake Assessment services and annual reassessment services. As of 10/1/2021 we won't be using H0031 for our intake assessments. Would it be possible to use the WX modifier on other assessment codes if the LOCUS is a part of that service? Like for example, if an Intake Assessment is coded to 90791, could we use 90791 WX? If not, would it then be the State's expectation to see two claim lines on the Encounter, if the assessment was rendered on the same day as LOCUS? One for 90791 (intake), one for H0031 WX for the LOCUS portion?	We will be updating the code chart to allow the WX to be added to all the assessment codes found in the H0031 crosswalk. The use of 90791 WX will be allowed, and reporting will only be one encounter. Update: It was asked if the WX could be added to the T1017 and H0039. ~~The LOCUS is a separate activity from case management. Utilize the appropriate assessment code with the WX modifier.~~ ACT clinician would provide the LOCUS as part of the bundled service. We will add to H0039 to show when the LOCUS is provided. 9/3/21: we have added the WX to T1017.
Will you look at the code chart for S0280 and give me your opinion. The modifier tab show HG as being removed for FY22. However, the S0280 in the Code Chart tab show it being used.	The modifiers tab will be updated to reflect the HG will remain for SFY2022 for Opioid Health Home (S0280) only.
I noticed that G2067, G2068, and G2073 are not listed on the new code chart. Are these codes changing or being removed as of 10/01/2021?	We will add these codes back to the code chart and will note that they are only for the dual eligible (Medicare/Medicaid) population.
• According to the new Code Chart when we are looking at modifier W7 we are only seeing that noted for H0019. A number of our affiliates felt that would also be used for H0010, H0020, and H0018. Can you confirm what Codes the state is expecting to see W7 on? • We wanted to make sure we are setting up group modifiers correctly and there was some question in the region about who counts as a group member. Is it only the individuals in the group the PIHP is paying for… or do have those entering the claim account for total number of consumers in the group? • For number of people served- 2 CMH + 5 private insurance pts do we report 7 or 2	We agree that it should be on H0018 and it is listed for H0018 on the code chart. H0010 – W7 will not be added. H0020 - W7 will not be added. • Answer – 2 would be counted. Just count the CMH consumers not the private insurance patients.

Question	Answer
• If we have families or caregivers are present for the group- does this also include those individuals. • For codes with limited credentialling modifiers identified, for example- CLS service provided by those with less than a bachelor, would we restrict use to only that modifier, is the state going to flag as an error if modifiers indicating a higher level of education are applied, If someone had a bachelors or even a Master would we report that code.	• Only count CMH active/open consumers and not family/support persons. You would report the highest level allowed for that code. If the code only lists up to bachelor's and a master's level provides the service, you will report the bachelor's modifier. Update and example: please select the provider that best fits who is providing the service. If the educational level is not listed, such as a Doctor of Occupational Therapy, then please pick the next highest degree that fits which would be Master's unless they are a Physician. Please note the qualifications and qualifying modifiers listed are a non-exhaustive list, use the staff level modifier that best represents the qualifications of the rendering staff. The Current Provider Qualifications column contains an exhaustive list.
Can we please get HO added to this so we can bill/report our Limited Licensed Psychologist (LLP)? 	~~We have added the HO provider level modifier to H2000. This would be for master's level limited licensed psychologists.~~ Update: we are removing the HO from H2000. This caused confusion since the Limited Licensed Psychologist should be using the AH per the Job Title-Modifier Crosswalk.
Would you mind confirming please – which of the following is correct when we complete both a CAFAS/PECFAS and another type of clinical assessment: 1. MDHHS wants us to report one encounter – but we need to make sure that the clinician who performed the clinical assessment is qualified to perform a CAFAS/PECFAS, because the assumption is that the encounter should/may have encompassed the completion of a CAFAS/PECFAS. 2. MDHHS wants us to report two encounters – one for the CAFAS/PECFAS assessment and a second one for the other type of clinical assessment, selecting from the codes you provided below as appropriate.	If the CAFAS/PECAFAS is being done as a part of the initial/periodic assessment then you would only report one encounter and yes, the clinician who performs that assessment does need to be qualified to perform the testing. MDHHS wants us to report one encounter – but we need to make sure that the clinician who performed the clinical assessment is qualified to perform a CAFAS/PECFAS, because the assumption is that the encounter should/may have encompassed the completion of a CAFAS/PECFAS. This is only if, the CAFAS/PECAFAS is being done as part of the initial/periodic assessment and not being done separately on a different day/time.
Question about the need for a modifier for a Behavioral Technician billing for CPT 97513. When we look at the Code Charts tab in the SFY 2002 Behavior Health Code Charts and Provider Qualifications that is currently on the MDHHS Website, for CPT 97513 it shows HM – Less than	The 97153 should report the HM modifier for Behavior Technicians. Previous guidance above was updated to include this revision.

Question	Answer
Bachelor's Level. When we look on the Job Title Modifier Crosswalk tab it shows Behavioral Technician under the HM modifier. We believe we should be adding the HM modifier in our I system to reflect this for reporting to MDHHS because these seems to be where the Behavioral Tech providing the service falls. Other for EQI reporting we would have not modifier to report under for the vast majority of the services provided for the CPT. The email below indicates that we are wrong and no modifier is necessary. E-mail: BTs will not need to have a degree modifier added. Below is a snip from the FY22 Code Set TA questions and answers. I also included a link to the document for you.  when including the credential modifier would we use the HO? For ABA services if a Behavioral Technician has a bachelor's degree what credential modifier are you looking for as the HN is listed for the BCBA? | There is not a modifier requirement for Behavioral Technicians.	
H0031 Crosswalk question for ABA assessments and ADOS testing	Earlier in this document we recommended that the 96116 be the replacement for the H0031 for ABA assessments. Lyndia Deromedi pointed us to some research that was done as to what codes best reflect the ABA assessments. DBPCodingUpdate2019final.pdf (washington.edu) According to this document it states that while the 96116 works, the better two codes to use for ADOS testing are 96112 and 96113.
Looking at 97153 as an example, if a provider hires a "behavior tech" to render 97153, but the behavior tech has a bachelor's degree but is not a BcaBA, what modifier does the State recommend they use? HM for less than bachelor's degree would not be accurate, but HM is defined particularly in the ABA codes for use of BcaBA.	We are really looking at the role the provider is and not the individual's personal education level. So, for 97153 we have the BT listed so you would choose the BT role not based on degree level. The BT may have a master's degree but again you would pick the provider modifier listed which is the HM.
For 0373T the BcaBA qualifications modifier is listed as HM, where elsewhere on the document it directs HN to be used for BcaBA. Might just need correcting?	This was an error. We have corrected 0373T for the BcaBA to have the HN modifier.
While reviewing the SUD services, I observed a couple retiring modifiers are included in the Reporting Code Description column. a. 90785 – the HF modifier is included b. T1012 – the TT modifier is included Should these be removed?	MDHHS fixed these lines to remove the references to the HF and TT modifiers in the Reporting Code Description column.
Transportation to be inclusive of program service code or report transport code separately for following daytime	Separate reporting for these costs was postponed until FY23.

Question	Answer
programs/activities scenarios? (Some of the following codes listed on the FY22 Code Charts column for the costing consideration list transpiration as inclusive and some do not) Please confirm leaving transport costs to/from/during service as inclusive within the daytime activity program codes (CLS, Skill Build, Clubhouse, Drop-In, OP clinic visits) remains appropriate for costing and reporting until FY23? Please confirm leaving transport costs to/from/during service as inclusive within the daytime activity program codes (CLS, Skill Build, Clubhouse, Drop-In, OP clinic visits) remains appropriate for costing and reporting until FY23?	Yes, this is correct.
What code should CMHSP use to pay a provider (Ex: psychologist) to attend Behavioral Treatment Committee meeting to present a behavioral plan writing for approval by BTC (Client not present)? Historically we have been using a "H0032 TS" as part of plan development, but this code requires face to face and consumer is not present at BTC?	The H2000 – Behavior Treatment Plan Review with the TS would be the best fit for this. • Service does not require face-to-face with beneficiary for reporting. • Minimum staffing: Three individuals that include psychologist and physician or psychiatrist. In order to report, at least two of the three must be present. Use TS modifier when a committee member or their designee monitors the activities of the behavior treatment plan. TS - Monitoring Treatment Plans There is one submission of the H2000 as a team code. The facilitator of the process is the person recording/submitting the code, which is submitted once as an encounter. Others are considered members/attendees, not billable participants. ~~The case manager, if attending, would bill the case management code if not the facilitator.~~ Removed this verbiage as to bill T1017 the beneficiary must be present, and the beneficiary would not be in attendance of the BTC.
The Medicaid Provider Manual has historically specified for Targeted Case Management that: *[Services include **assessment**, **planning**, linkage, advocacy, coordination and monitoring to assist beneficiaries…].* The State has therefore instructed previously that case managers should use T1017 for any of these activities AFTER the consumer has been authorized for ongoing TCM services—i.e., AFTER an intake clinician has already completed and coded the *initial* BPS (H0031) and planning (H0032) appointments during which it was determined whether to authorize or deny the provision of services.	Although there is an expansion of what is defined as TCM, the use of T1017 for these services has not changed. T1017 will continue to be used by CSMs for assessments, plans, etc.

Question	Answer
For FY22, do you expect services such as the annual BPS, IPOS meetings, IPOS reviews, to all be reported as T1017 once the consumer has already been receiving ongoing TCM? Or are you now expecting case managers to use codes such as 90791, H0032, etc. for these types of services even when they occur AFTER the initial BPS and plan?	
There is also related confusion with the LOCUS. If MDHHS wants annual/periodic assessments coded as T1017 for Case Management consumers, then it would seem that the WX modifier needs to be added as an allowable modifier for T1017 if the CSM is doing a LOCUS during the annual assessment session. Please confirm whether that is the intent. When it's in conjunction with/part of the case manager's annual BPS? Doesn't seem to be consistent with page 14 of the TA document where only one encounter is reported. It's going to generate another encounter line if they're not allowed to put the WX on the T1017 (or H0036 or H0039).	A LOCUS assessment done by a bachelor's level case manager would be reported as H0031 WX HN, HN modifier indicating bachelor's level. ~~The LOCUS is a separate activity from case management. Utilize the appropriate assessment code with the WX modifier.~~ ~~-~~9/30/21: we have added the WX to T1017.
Are the U modifiers for multiple clients served in Home Based to be used for multiple families?	The U modifiers are for the patients/consumers being served and not the families. Only open consumers should be counted.
The annual BPS provided by the Case Managers also includes the LOCUS assessment, I don't see where WX has been included as a modifier for T1017.	~~A LOCUS assessment done by a bachelor's level case manager would be reported as H0031 WX HN, HN modifier indicating bachelor's level. The LOCUS is a separate activity from case management. Utilize the appropriate assessment code with the WX modifier.~~ 9/30/21: we have added the WX to T1017.
The annual BPS provided by the ACT workers also includes the LOCUS, I don't see where the WX has been included as a modifier for H0039 either.	ACT clinician would provide the LOCUS as part of the bundled service. We will add to H0039 to show when the LOCUS is provided.
PMTO Certifications – For staff who have completed training but have not yet received the Certification (apparently these are taking a while to get) can we use the Y3 once training is completed? I thought I saw a statement somewhere that talked about a transitional modifier.	There is no transitional modifier. Use the Y3 modifier when the training and certified in the model is complete.
1. According to the Code Set Technical Assistance, the WX will be added to all assessment codes found in the H0031 crosswalk. If I am reading this correctly, this is being done for two reasons: 1. To ensure that when the LOCUS is completed as part of the initial/annual Assessment only one encounter is reported. 2. To ensure the completion of the LOCUS is reported This is a great option for those master's level clinicians who utilize the assessment codes. My question is what about the case managers? The time the case manager spends completing the assessment is built into the T1017. If the LOCUS is	A LOCUS assessment done by a bachelor's level case manager would be reported as H0031 WX HN, HN modifier indicating bachelor's level. The LOCUS is a separate activity from case management. Utilize the appropriate assessment code with the WX modifier.

Question	Answer
completed as part of the annual assessment would we be reporting one encounter still? Would this be T1017 WX or should we report the encounters separately as T1017 for the assessment and H0031 WX for the LOCUS?	
In talking with some regional partners I have discovered that some report the assessment and treatment plans developed by Home Based master's level clinicians as H0036 while others report those activities as H0031 (soon to be 90791) and H0032. Can MDHHS provide guidance on the proper reporting of these activities?	H0036 should be used.
Does the BCBA –Master's (HO) need to be added for S5111? Looks like the BCaba – Bachelor's level is only listed.	We cannot list every possible provider for each code. You should pick the provider modifier that best fits.
My understanding is that the H2000 is to be reported as one encounter for the meeting where the BTC discussed the consumers chart. If we paid a provider using that code, we could not also record another H2000 for the rest of the members that attended, correct? This will be very difficult if we encounter this situation.	There is one submission of the H2000 as a team code. The facilitator of the process is the person recording/submitting the code, which is submitted once as an encounter. Others are considered members/attendees, not billable participants. ~~The case manager, if attending, would bill the case management code if not the facilitator.~~ Removed this verbiage as to bill T1017 the beneficiary must be present, and the beneficiary would not be in attendance of the BTC.
Checking in this, to make sure I'm clear, the list of qualified providers/modifiers in the qualification section of the code line on the chart is non-exhaustive? So for example, H2011, the peer staff type modifiers are not listed, but per the Medicaid Provider Manual, Peers can be a part of ICS teams. Would we report H2011 with the peer modifier or would we need to use the modifier of the supervising physician or staff?	The peer would use their own peer services code such as H0038 to report and not the actual crisis code. Same for supported employment and others.
With the certified peer support modifier no longer being allowable for H2023 services, for IPS services, is it still allowable to utilize a peer?	• When a peer is acting within the peer role then they would report their applicable peer code (e.g. H0023, H0038) • If the peer is a qualified provider of the service (e.g. H0039 WS) then they would report that. • If the peer is not acting as a peer but is doing another type of service, such as transportation, then they would report that applicable provider modifier because they are not being a peer but instead providing a different service.
Questions related to group Modifiers (U modifiers). How do providers account for extra staff sharing facilitation of a therapeutic group or group activity… Are all CMH consumers accounted for and given a modifier that reflets total number	Please refer to both to CMS regarding definition of group and double billing. I am copying some sources below:

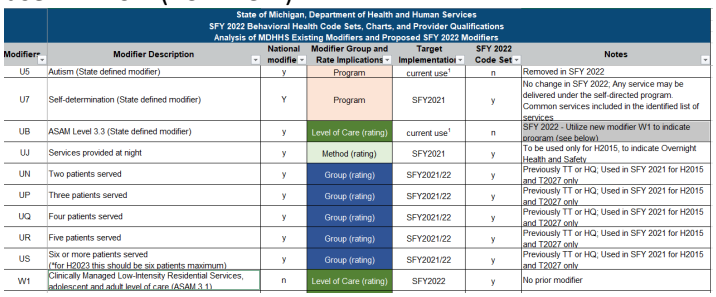
Question	Answer
served or are we breaking consumers up in coordination with staff present? Example If we have 6 CMH consumers and 2 staff: Do we report a 3 person group/UP or a 6 person group/US. If we have a large group of 18 consumers engaging in a group community outing with 4 staff. 1 staff is activity supporting 2 consumers identified with higher needs and the remaining consumers are split between the other 3 staff. Do we code all consumers with the correct code and a US modifier or break them up according to staff support? 2 consumers receive a UN 6 Consumers at a US And the remaining 10 consumers each coded with a UR.	CMS definition of "group": Individual and group psychotherapy may be individual therapy with 1 or more therapists or more than 1 individual in a therapy session with 1 or more therapists. Medicare Mental Health (cms.gov) Double billing: If two staff persons provide a service such as group therapy, can both of them bill? No, claims with duplicate line items will be rejected as double billings. Billing FAQ (washington.or.us). This would be when two staff provide services to one group. Both cannot bill the same beneficiary for the same service. What is Double Billing in Medical Billing - Capline Medical Billing (caplineservices.com) "In medical billing, double billing is commonly defined as a provider's attempt to bill Medicare/ Medicaid, be it a private insurance company or the patient for the same treatment, or when two providers attempt to get paid for services rendered to the same patient for the same procedure, on the same date." What is Double Billing in Medical Billing - Capline Medical Billing (caplineservices.com)
Can you tell me if the HM modifier is required for services such as H2014, H2015, Clubhouse etc.? I don't see it on the BH Code Set List but it is listed under the Code Charts.	So, for the H2014 and H2015 there are no staff/provider level modifiers required. Clubhouse does have provider level modifiers.
I'm looking for some information around the T1040 code. The chart states "This procedure code is an indicator for CCBHC services and should be included as an additional claim line on all CCBHC encounters". So, if we have a consumer that receives a service (E/M therapy etc.) would be include that code (99214 plus the T1040) on the encounter to show that the consumer is CCBHC? Just trying to make sure I understand what you mean by indicator.	The T1040 applies ONLY to the CMS CCBHC Demonstration Sites, not the SAMHSA CCBHC Expansion Grantees. We will make that clear and look to communicate that to all of our PIHPs and CMHSPs, too.
We are wondering if we need to use the HM modifier for both T1005 Respite and H2015 Community Living Supports. I know there is a disclaimer at the top of the chart that states this is non-exhaustive list for modifiers, but we want to assure we are in compliance with MDHHS reporting requirements. We noticed the job title modifier chart lists Direct Support Professionals (DSP) using a HM modifier - We see the code charts under T1005 Respite lists DSP with a reportable modifier of HM.	The H2015 has only one qualified provider, therefore no modifier is needed. Regardless of the credential of the person providing H2015, they are acting as a DSP when providing this service. The other example (T1005) has more than one qualified provider, so the HM is included.

Question	Answer
However, under H2015 CLS the provider qualification lists DSP as performing the service but does not list the HM modifier. Should we attach the HM modifier to both codes T1005 and H2015? Additionally, we sometimes have a nurse provide H2015, should we attach the TE or TD to delineate the service provider despite that provider not being listed?	
I noticed that the U modifiers are allowed on the family therapy codes, but that doesn't make sense to me since you are just serving one family at a time. Can you help me understand when we would report multiple consumers for that service?	~~The family therapy codes are also intended for group therapy, so the U modifiers apply to the group therapy sessions.~~ We removed the U modifiers from 90846 and 90847 as that is family therapy and kept the U modifiers on 90849 as that is multi family therapy.
I need a little clarification. Can the LMSW do the Behavior Plan monitoring (H2000 TS), just not the H2000?	As the provider qualification notes that TS can be used by a member or designee, it makes sense to add the modifier to H2000.
If we have a LLBSW on the ACT team, can he provide the Hospital pre-screen (reported as H0039 WN)? Questioning this because Bachelor's level people cannot diagnose. If no, can he provide it if a master's level signs too?	When conducted as part of ACT, this would be appropriate since ACT uses a team based approach and is a bundled service.
I was looking at the code chart and I noticed that when this new chart was created they removed the definitions that were in there previously that would guide you in knowing which code to pick for example H2015/H2023 it used to say that if the person was on the job and only needed help with personal care and no vocational skills it would say select H2015 CLS. But all of that seems to be missing. Is there someone we can ask at the state if they plan on putting that information back in there or not?	We will add this information back into the code chart in the Reporting and Cost Considerations columns for codes H2015 and H2023.
We are still working through the transition away from H0031. A question came up about 96116 and 96121. Both are identified as being for use within a 60 minute time frame. Our question is if these codes are not used for a full hour of direct time can they still be used. For example 96116 is identified to be used for the first 60 min. if someone is see and the assessment/ session ends in 48 min are they still able to bill using 96116. Subsequently if you douse this code for an entire hour and the session extends to be 1 hour and 35 minutes can submit using both 96116 and 96121. Appreciate your thoughts on this.	The CPT codes have the following midpoint rounding rules: 3. The CPT rule states that if a unit of time is attained when the mid-point is passed. 2. Report a timed service based on face-to-face time on each date of service. 1. Select the service (see CPT code descriptions). **AMA CPT Code book for additional information on the reporting of a timed service.** **Ib. Rounding rules for CPT reporting:** Currently CPT Codes use mid-point rounding rules: If the code unit is for the "first hour" of service, then you must provide and document at least 31 minutes of service. Likewise, if the unit of service is 15 minutes then you must provide and document at least 8 minutes of service. Below is an example table for the 15-minute and 60-minute codes and how they would be counted when the rounding rule is applied. **Please refer to the** **60-Minute Codes** / **15-minute Codes** Unit / Time / Unit / Time 0 / 1-7 minutes / 0 / 1-22 minutes 1 / 8-37 minutes / 1 / 23-52 minutes 2 / 38-67 minutes / 2 / 53-82 minutes 3 / 68-97 minutes / 3 / 83-112 minutes 4 / 98-127 minutes / 4 / 113-142 minutes This table is on the "General Rules for Reporting" tab within the code charts and provider qualifications workbook.

Question	Answer
	Since the 96116 midpoint is reached at 31 minutes then an assessment that ended at 48 minutes would be billable.
I have referenced the technical assistance and seen where individuals questioned about the WX being added to the T1017, H0036 and H0039. I have seen where MDHHS has answered that the WX will be added and referenced the T1017 and H0039 but nothing for the H0036. Will the WX be added to the H0036 for when infant Mental Health clinicians complete the annual assessment which has the LOCUS included?	We will be adding the WX to the H0036.
Should regular Crisis Intervention be coded H2011 while Intensive Crisis Stabilization, is coded to H2011 HT? S9484 is listed in the mobile crisis cost category though? Are adult ICS services not considered mobile at this time? Adult ICS services are allowed to be rendered in the community, so I don't see how that isn't "mobile" but I think that's the difference currently, children's ICS are considered 'mobile' but adult ICS are not (per Medicaid Manual). There is some notes on the old chart about keeping S9484 for ICS services for adults but we opened up H2011 for mobile and ICS services for children, around the time the 'mobile' stuff was being implemented because most of the time the mobile ICS services were not an hour long so couldn't be coded to S9484. If the intent of the "mobile" cost center is to only capture costs and services for Children's Mobile ICS, then S9484 could be moved to the Crisis Services category, or be in both. In Crisis Services without the HT modifier for ICS for adults and in the Mobile Crisis category with the HT modifier for 'Mobile Crisis' for children, or just in the Crisis Service category for non-mobile ICS, and all "mobile" ICS only be coded to H2011 HT. Just to note, because our ICS teams do go into the community, it's confusing to think of Children's ICS as "mobile" but adult ICS is not, because technically it is, so not sure if there is something we can do about that confusion and just call all ICS mobile.	As of right now the adults and kids can use the H2011 HT for mobile crisis. However, we expect that this will change as we will need to be able to track on whether the beneficiary is enrolled in an child or adult program.
Currently we are using H0031 to report Functional Behavior Assessments completed on individuals who are not involved in ABA services. A comprehensive functional assessment includes: a. a review of records for psychological, health and medical factors which may influence behaviors (e.g. medication levels, sleep, health, diet, psychological and neurological factors); b. an assessment of the person's likes and dislikes (events/activities/objects/people);	MDHHS will open the 97151 to non-ABA beneficiaries.

Question	Answer
c. interviews with the individual, caregivers and team members for their hypotheses regarding the causes of behavior; d. a systematic observation of the occurrence of the identified behavior for an accurate definition and description of the frequency, duration and intensity; e. a review of the history of the behavior and previous interventions, if available; f. a systematic observation and analysis of the events that immediately precede each instance of the identified behavior; g. a systematic observation and analysis of the consequences following the identified behavior; h. analysis of functions that these behaviors service for this person; i. get/obtain: interaction, reaction, desired activity, self-stimulation, other; j. escape/avoid/protest: an emotional state, demand/request, activity, person, other; k. an analysis of the settings in which the behavior occurs most/least frequently. Factors to consider shall include the physical setting, the social setting, the activities occurring and available, degree of participation and interest, the nature of teaching, the schedule, routines, the interactions between the individual and others, degree of choice and control, the amount and quality of social interaction, etc. There are no codes on the H0031 crosswalk that fit what is completed during this type of assessment. There is however, under the ABA benefit, the 97151 Behavior Identification Assessment which consistent with what is completed in an FBA. Would MDHHS look into allowing the 97151 for use with other populations?	
I've been asked by one of our contract agencies if Supported Employment, H2023 can be provided at the same time as CLS, H2015? The agency is stating the provider was providing job development activities, non-face to face, while the individual was in program receiving CLS services.	Indirect services code may not occur at the same time. Like the majority of our services, they can't be used "at the same time" in terms of actual time (e.g., more than one service being provided from 11:00-11:15 a.m., for example)… there would not be an issue with an individual receiving services for both SE and CLS as long as both are identified in the IPOS and are medically necessary.
Can H0039 be reported with the Peer Recovery Coach modifier WR?	We will add the WR to H0039.
1. Is telehealth no longer available for 97153, Speech and OT codes? We do not see the GT modifier in Program Modifier Notes/Column G in the SFY 2022 Behavioral	1. Yes, these are still available on the COVID-19 Encounter Code Chart is still in effect. Once this chart goes away after the deemed Federal PHE is over then you will start using the BHDDA

Question	Answer
Health Code Charts and Provider Qualifications Spreadsheet. 2. Our contracted Dietician has historically used Treatment Planning/H0032 TS when monitoring dietary treatment plans. We know AE has been added to Dietary codes. Do we need to add AE to H0032 TS when the Dietician is providing this service or is AE not a modifier for this code? Or because AE is not listed is treatment planning/H0032 TS no longer available for the Dietician to use?	Telemedicine Database that is on our reporting requirements page. 2. The dietician modifier is not listed; however, please select a provider level that best fits for the dietician. We cannot possibly list every profession and degree, or the chart would never end.
I was asked by a supervisor if a LLMSW could render the 90791 for an assessment. I went to the code chart – noting in the current provider qualifications chart (which is supposed to be an exhaustive list), it does not speak to limited license. My answer would then be no to the supervisor, but I wanted to double check my interpretation since we switched to the new multi tab format for the code chart – which I love but want to be sure I am using it properly. Previously there was a statement about limited license supervised by fully licensed – is that statement somewhere in the new spreadsheet? Please advise.	The HO is for both limited licensed and licensed MSW's per the Job Title-Modifier Crosswalk: HO | Licensed/Limited Licenses Social Worker - Master's See statement on Qualifications Crosswalk tab: Social Worker - Individual who possesses Michigan full or limited licensure as a master's social worker or a bachelor's social worker. Social workers with limited licenses must be supervised by a fully-licensed master's social worker.
Should the HN be added to the respite code in case we do have a bachelor or above staff providing respite services? Are you expecting that T1005 will always be reported with a modifier? Just circling back to this – what if the provider actually had a bachelors degree. Would they still use HM because a bachelors degree is not required? Our providers are struggling with the concept.	The provider level modifiers for T1005 are HM, TD, and TE. You would pick from those the most appropriate. Yes, that is correct. A degree is not required; therefore, they would still use the HM unless they are a nurse.
The region also was hoping to see if we could have T1023 looked at for use with the WX modifier. This will help us report that a Locus was completed during a prescreen.	MDHHS will add the WX to the T1023.
I would like to request clarification on a modifier example. T1005 and H0045 require a credentialing modifier. I see that H2015 and H2014 do not require a modifier because it was determined that the credentials of the provider would not impact the rate. Wouldn't this be true for Respite? I know that we have some family respite providers that hold a degree, but the rate is not different. And their degree may be in an unrelated field. Can you confirm that the credentialing modifier is required for those services and if there is a specific field of study for providers with higher education?	There are nursing respite services. PDN services has a nursing respite option that is included in the HSW and CWP which is the reason they have indicated the modifier for the RN or LPN to provide this service. It is specifically for individuals who require skilled nursing interventions for 24 hours per day which the maximum amount a nurse can provide is 16 hours where the family or responsible caretaker would provide the other 8. In situations when the family is not available a

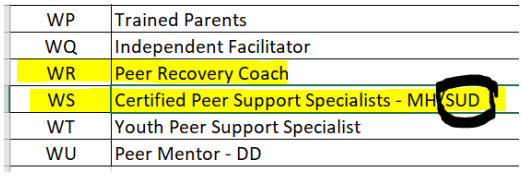
Question	Answer
	second nurse is required to provide this service for those hours the family is not there. The rate reimbursed for this respite service is higher because of the skilled nursing interventions they are providing which can only be provided by a RN or LPN.
Could you please clarify whether Place of Service code 12 (Home) is an acceptable POS code for the 9083X code series?	Per Medicaid and CHAMPs: 90832—both facility and non-facility rates 90833—both facility and non-facility rates 90834—both facility and non-facility rates 90836—both facility and non-facility rates 90837—both facility and non-facility rates 90838—both facility and non-facility rates 90839—both facility and non-facility rates POS 12 (home) is in the non-facility group. **All these codes can be performed in either the facility or non-facility location and POS 12 is in the non-facility group so it can be performed at home.**
It looks like the note for modifier UB is incorrect. UB was previously used for ASAM level 3.3 so I do not think we should use W1 now (ASAM 3.1).  Will you look into this and confirm for me?	We will correct this line in the Modifier tab so that it read W3 and not W1.
If the HM modifier for DSP were to be reported on codes that do not require it (H2014, H2015, T2015, T2027), would those be accepted as encounters? Would there be any issues if the modifier was reported for a period of time and then not reported on those codes?	The only issue this may cause is in possible future data analysis and putting it into two different pockets – one with the HM and one without. System-wise it shouldn't be an issue though.
What is the daily threshold amount for H2019 (DBT)? The SYF tool only indicates that it's a 15-min code.	The DT would be 4 per day.
So, there is only one credentialing modifier for H0045 respite. Therefore, my guess is that we should never report this without a modifier and it will always be HM – accurate? Our system is set up to require a modifier but I fear if we don't make a modifier required that we will get no modifier. This seems kind of odd to me – comments?	That is correct. The reporting would always include the HM modifier.

State of Michigan, Department of Health and Human Services
SFY 2022 Behavioral Health Code Sets, Charts, and Provider Qualifications
Analysis of MDHHS Existing Modifiers and Proposed SFY 2022 Modifiers

Modifier	Modifier Description	National modifie	Modifier Group and Rate Implications	Target Implementatio	SFY 2022 Code Set	Notes
U5	Autism (State defined modifier)	y	Program	current use[1]	n	Removed in SFY 2022
U7	Self-determination (State defined modifier)	Y	Program	SFY2021	y	No change in SFY 2022; Any service may be delivered under the self-directed program. Common services included in the identified list of services
UB	ASAM Level 3.3 (State defined modifier)	y	Level of Care (rating)	current use[1]	n	SFY 2022 - Utilize new modifier W1 to indicate program (see below)
UJ	Services provided at night	y	Method (rating)	SFY2021	y	To be used only for H2015, to indicate Overnight Health and Safety
UN	Two patients served	y	Group (rating)	SFY2021/22	y	Previously TT or HQ; Used in SFY 2021 for H2015 and T2027 only
UP	Three patients served	y	Group (rating)	SFY2021/22	y	Previously TT or HQ; Used in SFY 2021 for H2015 and T2027 only
UQ	Four patients served	y	Group (rating)	SFY2021/22	y	Previously TT or HQ; Used in SFY 2021 for H2015 and T2027 only
UR	Five patients served	y	Group (rating)	SFY2021/22	y	Previously TT or HQ; Used in SFY 2021 for H2015 and T2027 only
US	Six or more patients served (*for H2023 this should be six patients maximum)	y	Group (rating)	SFY2021/22	y	Previously TT or HQ; Used in SFY 2021 for H2015 and T2027 only
W1	Clinically Managed Low-Intensity Residential Services, adolescent and adult level of care (ASAM 3.1)	n	Level of Care (rating)	SFY2022	y	No prior modifier

Question	Answer
I had asked the question at the MARO Conference last week regarding the LOCUS assessment WX modifier. Currently, the way we do a LOCUS is within the initial screening. We code our screenings H0002. Does the state want to see the use of a LOCUS assessment reported? Is it okay to leave it as part of the initial screening? We do also have a separate LOCUS assessment document that is used during annual reviews and/or when a consumer needs a different level of care, etc. We can add a screen to this document to be able to report the WX mod going forward if the state is want to see when a LOCUS assessment is provided.	The WX is on the H0002. So, you would report one encounter with the WX. We added the WX to all the codes that were available in the H0031 crosswalk previously.
One of contract agencies who provide Skill Building, H2014 and CLS, H2015 inquired if a Bachelor level staff can supervise staff who provide these services. I believe staff providing the service(s) have less than a bachelor's degree. I reviewed the Provider Qualifications document but didn't find anything definitive. Can you tell me if MDHHS allows for a Bachelor level staff to supervise staff who has less than a Bachelor's degree and/or a High School Diploma?	Individual responsible for the IPOS could be bachelor's level or higher. Supervision is needed in terms of coordinating service hours, orientating DSP to families wishes and preferences, orientating the DSP to the IPOS etc.
MDE – Certified School Psychologist - I looked in the qualifications tab for this license related to a psychologist. Is this a credential that would fall under the psychologist title?	We don't require anything behind the LARA psychology licensure. And LARA's only issues licenses at a profession level (i.e Psychologists, Psychologist Masters Limited License,) not at an expertise/certification level (i.e. Educational). Just to double check, I reviewed the LARA licensure list as well as the LARA Administrative rules for Psychologists and I didn't see any references to a specialized qualification/certification level. Anything at this level, would be through a different authority.
We have two questions pertaining to this change: 1. Effective 10/1/21, per the Provider Qualifications and Coding Charts, Certified Medical Assistants are now allowed to bill for Medication Administration. Per the code chart are certified Medical Assistants granted same permissions to administer medications the same as the other professionals listed on the code charts (i.e, psychiatrists, physicians, Nurse practitioners, etc). Is this correct?	This change was made back at the end of June so is not a new change effective 10/1/21. Refer to our old chart and you will see it listed: PIHP/CMHSP Provider Qualifications Chart (Updated 6/28/2021) To clarify, the question is related to scope of practice/whether a certified medical assistant may administer a psychotropic under the delegation and supervision of a physician (and not if Medicaid reimburses for the administration of the drug)? CMA services would seemingly fall under the Practitioner Chapter, Section 3.13.C.,

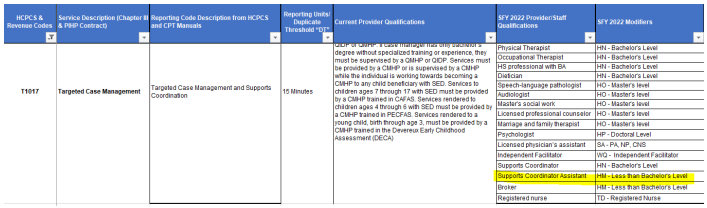
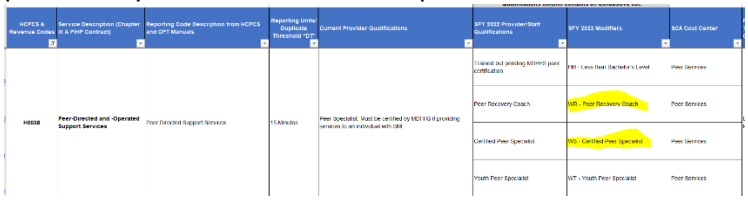
Question	Answer
2. It is my understanding that the Certified Medical Assistants are not licensed by LARA. Also, in Michigan, any individual performing this role must be certified by either the Certified Medical Assistant or the Registered Medical Assistant (RMA). Therefore, only certification is needed. No licensing from LARA is required at this time. Is this correct? We are looking for support or documentation as to how a Certified Medical Assistant can provide and report 96372. Can you please provide us with these reference documents.	"Injections in the office/clinic/beneficiary's home may be administered by appropriate non-physician staff who are employed by the physician or are employed by the same clinic/group as the physician. Administration of the injectable drug by non-physician staff must be under the physician's personal supervision or under the delegation and supervision of the physician as required by the Public Health Code." You would need to refer to the public health code regarding the specific class of the drug in question and whether that service may be delegated to an unlicensed provider (schedule II vs schedule III drug etc.). Medicaid policy is quite clear - Practitioner Chapter, Section 1.7 Physician Delegation and Supervision (noted below). Medicaid covers services delegated to unlicensed/certified persons only when the delegating physician or licensed non-physician practitioner is physically present and providing direct supervision.
Individuals that use T1012 do not meet the qualifications for H0038, but they may not necessarily have a license or MCBAP certification. If they don't meet one of the listed groupings, should the default modifier be HM?	We will be adding the HM to T1012 for 'Other Mental Health Professional - HS or G.E.D.'
Per the Medicaid Provider Manual, a provider who has a high school equivalency & work or life experience can provide ACT services. Per the SFY2022 Behavioral Health Code Chart, there isn't an option for Modifier HM, less than a Bachelor's degree. I wasn't sure if the HM modifier was overlooked or if a Mental Health Assistant can longer provide ACT services as of 10/1/21.	We will be adding the HM to ACT for 'Other Mental Health Professional - HS or G.E.D.'
Regarding ABA service 97151. It appears we will recognize the BCBA Certificate as an HO, but should we also be recognizing the Licensed and Limited License Behavior Analyst? The BCBA is required to become licensed as a Behavior Analyst and there is probably pay scale differences in the BCBA and LBA/ALBA. Each would still be reported with the HO modifier. The 96116 and 96121. These codes are going to be used to document the ABA Assessments previously documented as H0031:U5. The 96112/96113 have ADOS Standard Requirements and during the pandemic those standards cannot be met, so coding and following the criterial of 96116/96121 will be the best approach for the Autism Assessments – Here we don't list	MDHSS is reviewing this internally as this relates to the Autism Fee Schedule.

Question	Answer
the BCBA, I realize the BCBA and LBA/ALBA are Masters level but should we be recognizing the Certificate and the License? Thank you for reviewing and following up.	
I'm not clear from the MHHS code chart on which is the correct modifier for Peers. Per the **Job Title** modifier tab. A certified SUD Peer would use modifier WS.  Per the **Modifiers** tab the WS doesn't reference SUD.  Can you tell me which modifier is expected to be used for a Certified Peer Recovery Coach? Is the recommendation for **<u>Certified</u>** Peer Recovery Coaches to add the WS modifier? When do you recommend adding the WR modifier Peer Recovery Coach?	We are adding the MH/SUD language to the WS Modifier, so it matches the job title-modifier crosswalk tab. Yes. That's the actuarial intent. WR modifier will be reported for Recovery Supports under H0038 (and T1012 in some instances) delivered by trained but not certified peer recovery coaches (PRC). H0038:WR would be the preferred code/modifier combo when using WR Here's a PRC defined (excerpted from link below) <u>Peer Recovery Support Services #TA-T-07 (michigan.gov)</u> *Peer Recovery Coach - The name given to peers who have been specifically **trained** to provide advanced peer **recovery support services** in Michigan. A peer recovery coach works with individuals during their recovery journey by **linking** them to the community and its resources. They serve as a personal guide or mentor, helping the individual overcome personal and environmental obstacles.* Here are RSS defined in the same document. *Recovery Support Services - Non-clinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to, and coordination among, allied service providers, and a full-range of human services that facilitate recovery and wellness contributing to an improved quality of life. These*

WP	Trained Parents
WQ	Independent Facilitator
WR	Peer Recovery Coach
WS	Certified Peer Support Specialists - MH/SUD
WT	Youth Peer Support Specialist
WU	Peer Mentor - DD

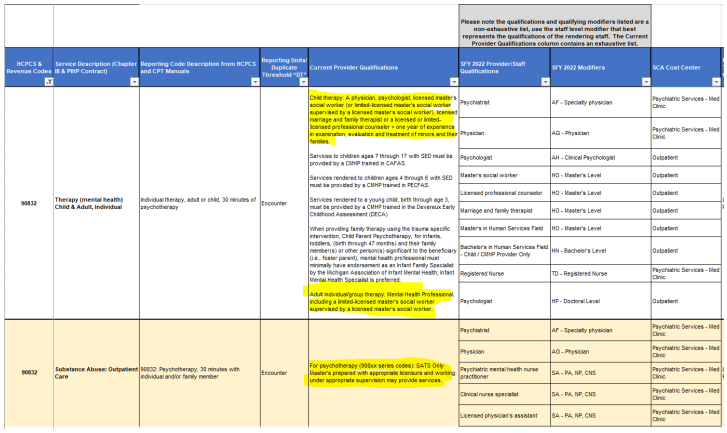
WR	Peer Recovery Coach	n	Provider credential (rating)	SFY2022	y	No prior modifier
WS	Certified Peer Specialist provided or assisted with covered service	n	Provider credential (rating)	SFY2022	y	Previous modifier HE

Question	Answer
	services can be flexibly staged and may be provided prior to, during, and after treatment. RSS may be provided in conjunction with treatment, or as separate and distinct services, to individuals and families who desire and need them A certified peer specialist (CPS) can coach but is allowed to and qualified to provide/assist with other covered services beyond RSS described above. They can assist or lead groups (H0005), for example. As a rule of thumb, certified peers will be reported with WS (as you noted), for all services the provide or assist with Trained by not certified peers would be reported with H0038 or T1012 RSS.
I reviewed the MDHHS Technical Assistance document for any questions related to the LOCUS modifier and nobody has asked about adding this to outpatient therapy. I just want to confirm what my ask is from MDHHS – we are asking that if a LOCUS is completed during a therapy session, could the WX be added to 9083X – right? I did review an email between you, me and Jane about coding a progress note when just the stand alone LOCUS – is that the same situation? If so, the TA document indicates H0031 WX.	The WX was only added to certain codes – mostly the assessment codes and psych evals found in the crosswalk along with ACT and a few others. It would not be added to a therapy code. That should be reported as the H0031 WX. These are the codes the WX is allowed on besides the H0031: H0002, T1001, 97802, 97803, 97165, 97166, 97167, 97168, 97161, 97162, 97163, 96105, 96110, 96112, 96113, 96116, 96127, 90791, 90792, H0039, T1017, H0036, T1023.
We noticed that there were no notes regarding the "U" modifiers for code 97158 ABA Adaptive Behavior Treatment Social Skills Group. Was that an oversight and should we be using UN, UP, etc.? In regards to the WX modifier, we know we are allowed to use H0031 WX for a stand-alone LOCUS. The question I have is for departments that use T1017 and H0039, for a stand-alone LOCUS, would the use H0031 WX or would they use T1017 WX and H0039 WX?	We will add the U modifiers to 97158. Thank you for making us aware of this. If the LOCUS is being done as a standalone, then you would use the H0031 WX. If the LOCUS is being done along with a service, such as H0039 or T1012, then you would use that service code with the WX since both the H0039 and T1012 allow for the WX.
In the screen shot below, a Clinical Social Worker (HO) can do a LOCUS assessment, but a Clinical Psychologist (AH) can NOT do a LOCUS assessment. Both staff have a Master's degrees, and I believe both are qualified to perform a LOCUS assessment. Does this make more sense?	We are adding the AH to the H0031 WX.

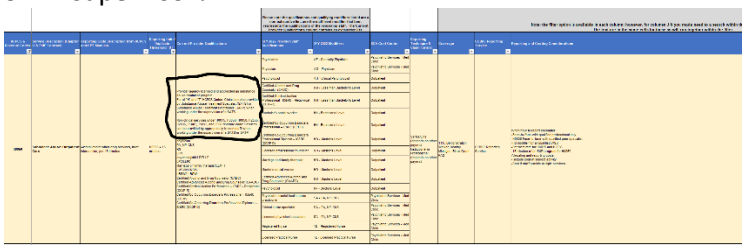
Question	Answer
	
The following information is part of the Same-Time Services Reporting tab. Should adult peers continue to report H0032 with either a WS or WR modifier? If so, would they also require one of the other listed provider qualifications or is certified peer sufficient? 1. Treatment Planning (H0032) can be reported by an independent facilitator and all professional staff for the same session. In addition, it can be reported by multiple staff at same time that the case manager/supports coordinator also reports that time using their own code: T1016, T1017, H0039, H0036, H2022, or H2021. It should be noted that only one staff person can attend an IPOS in the behavioral health case management role. In their role providing services and supports planning, Adult Peer Specialists and Recovery Coaches will report H0032 with their appropriate, respective modifiers. Youth Peer Support Specialists will report H0038 with the TJ modifier and Parent Support Partners S5111 with the HM modifier.	The Peer should report H0038 with the WR or WS. We will modify this outdated language.
West Michigan CMH has a Supports Coordinator Assistant who is also a Certified Peer Support Specialist. Which modifier does the State recommend on the T1017? HM – Less than Bachelor's Level Or WS – Certified Peer Support Specialist 	It depends on the role they are providing services in…so it if their role is as of the Peer then use the Peer modifier but if their role is the SCA then use the modifier for the SCA.
Please confirm that the modifiers WR (Recovery Coach) and WS (Certified Peer Support) are now required on all encounters provided by certified staff in these positions. 	If the Peer is not listed as a qualified provider of a service, then they would use their own peer code (such as H0023 and H0038). So, no not all encounters will have the Peer (WR/WS) modifier on them; only the services that include the WR/WS already (such as ACT) or the Peer service codes themselves. See previous guidance in this document where stated:

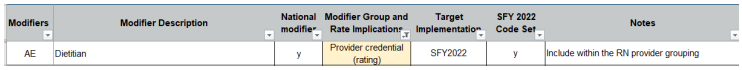
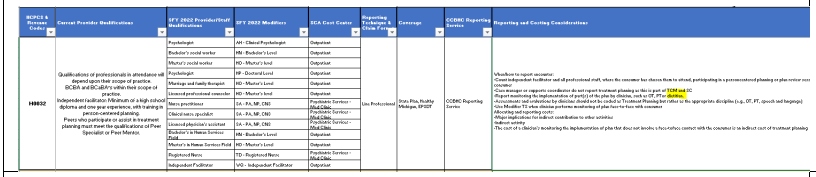
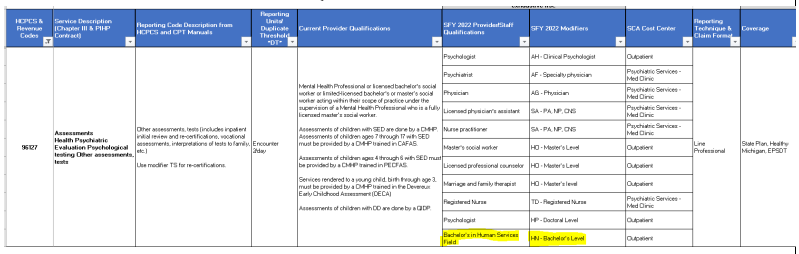
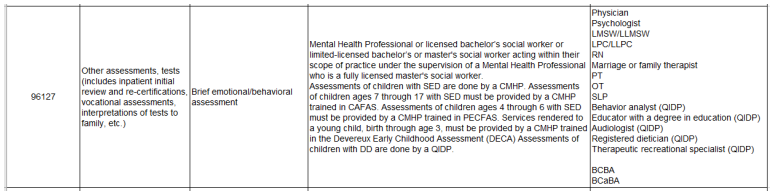
Question	Answer
	• When a peer is acting within the peer role then they would report their applicable peer code (e.g. H0023, H0038) • If the peer is a qualified provider of the service (e.g. H0039 WS) then they would report that. • If the peer is not acting as a peer but is doing another type of service, such as transportation, then they would report that applicable provider modifier because they are not being a peer but instead providing a different service.
I just wanted to confirm as there still seems to be some confusion pertaining to the modifier that should be used for 97153, 97154 and 0373T. These services are typically provided by a high school or college under grad student but at times may be provided by staff with a Master's or Bachelor's degree. When I review the TA it is clear that the HM should be reported regardless of the staff person's degree as it is more of a position modifier. Looking at 97153 as an example, if a provider hires a "behavior tech" to render 97153, but the behavior tech has a bachelor's degree but is not a BcaBA, what modifier does the State recommend they use? HM for less than bachelor's degree would not be accurate, but HM is defined particularly in the ABA codes for use of BcaBA. We are really looking at the role the provider is and not the individual's personal education level. So, for 97153 we have the BT listed so you would choose the BT role not based on degree level. The BT may have a master's degree but again you would pick the provider modifier listed which is the HM. I believe the confusion comes from the code chart listing all of the "degree" modifiers in the SFY 2022 Modifiers column. Is there anyway to add a statement to the code chart that indicates "Use the HM modifier regardless of the degree"? HCPCS & Revenue Codes / Reporting Units/ Duplicate Threshold "DT" / Current Provider Qualifications / SFY 2022 Provider/Staff Qualifications / SFY 2022 Modifiers 0373T / Per 15 Minutes (effective 1/1/19) / BT, BCBA, BCaBA, or QBHP, LP/LLP Physician — AG - Physician Psychologist — AH - Clincial Psychologist BCaBA — HN - Bachelor's Level BCBA — HO- Master's Level BACB approved degree — HO - Master's Level Behavioral Technician — HM - Less Than Bachelor's Level Licensed professional counselor — HO - Master's Level Master's social worker — HO - Master's Level Master's in Human Services Field — HO - Master's Level Psychologist — HP - Doctoral Level Nurse Practitioner — SA - PA, NP, CNS To close, would you please confirm that the HM modifier is to be used by all staff who perform the role of a BT and report 97153, 97154 or 0373T, regardless of personal education.	MDHSS is reviewing this internally as this relates to the Autism Fee Schedule.
- Should HH (Co-Occurring Mental Health and Substance Abuse) be used for H2023 services? -Is Y4 an applicable modifier for IPS services? If so, could you clarify when it should be utilized? (instead of HH).	MDHHS is reviewing this internally. We had added the HH Modifier to additional services since we received feedback from SAMHSA that MI is well below national average on providing services to individuals with CoOccurring disorders (COD)—not just specific EBPs for COD. Thinking was this would be the best way to track to make sure we are capturing a more realistic number of individuals being served.

Question	Answer
	Individuals with a primary diagnosis of serious mental illness remain the PRIMARY criteria for receiving IPS services. • Please do use the HH modifier to discern if the individual has a co-occurring disorder. This is valued by the State to better track services use by persons with co-occurring disorders. Do not use the Y4 modifier in conjunction with the Y5 modifier. Related to Y5, the Y4 modifier is not applicable.
We are getting much feedback from our providers regarding the OTA/PTA modifiers (i.e., CO & CQ, respectively). They are missing from H0032-TS (Treatment Plan Monitoring) and they are missing from S5111. Can you please add them to both procedure codes? (See Screenshot below). Another provider is complaining about "HM" not being allowed with H0036 (Home-Based), despite the code chart saying that a Home-Based Assistant is a DSP level staff. Please add HM to H0036.	We will be adding the CO & CQ to the H0032 and S5111. We will be adding the HM to H0036.
I stumbled upon another code question. S8990 is described as Physical or manipulative therapy performed for maintenance restoration. It is showing as being allowed as PT only, but I think this should remain and PT and OT as it has in the past. The credential modifier of CO for Occupational therapy assistant.	We have added a row for the S8990 Occupational Therapy, and it includes the CO for Occupational Therapy Assistant.
We have had some discussions recently about codes and modifiers and were wondering if you could provide some input. We are trying to determine the appropriate CPT code to use for our SUD engagement groups. Engagement groups in our region offer information regarding general themes of substance use and related behaviors. Groups are conversational, sharing, and psycho educational. Engagement level group participants are usually pre-contemplative, however, the service is also available to all open consumers. These groups are facilitated by either a Peer Recovery Coach or a Case Manager. Options we've discussed: **H0022-Early Intervention Services**-Encounter • Makes the most sense but requires minimum Bachelor's/CADC and most of our Recovery Coaches do not meet this requirement and no U modifier. **T1012-Recovery Supports**-Encounter • We use this for case management. Requires minimum Bachelor's/CADC and states appropriately trained staff who are not certified peers. **H0005-Sub Abuse: Outpatient Care**-Encounter	MDHHS is reviewing this internally.

Question	Answer
• We use this for our treatment groups. Requires minimum Bachelor's/CADC and most of our Recovery Coaches do not meet this requirement **H0006-SUD Case Management**-Encounter • Only block grant and PA2. **T1012 Recovery Supports-**Encounter **and H0038 WR Recovery Coach**-15 min unit • Consumers would receive the same service (engagement group), however, each discipline would use their appropriate code. Case manager would use T1012 with U modifier and recovery coach would use H0038 WR with the U modifier. Base rate for each code would be different even though the service is the same. In addition, the Reporting Units would also be different for the same service (encounter/15 mins). Do either of these differences raise concern? Do you have any suggestions or thoughts on the above codes?	
I am looking for clarification on how we should be submitting services that reference "when supervised by". Does this mean the encounter should be sent with the rendering staff or by the supervising staff of the rendering provider? A couple examples I have below to maybe understand my ask a little better: Looking at 90832 – The Current Provider Qualifications states for child and adult both: "…including a limited-licensed masters social worker supervised by a licensed masters social worker". Do you want to see the limited staff come through on the encounter or do you want to see the supervisee fully licensed staff listed on the encounter?  Another example is for H0050, we have a Certified Peer Recovery Coach proving this who is supervised by a SATP, so is this okay?	You would report the rendering provider, the person providing the service, not the supervisor. For 90832 you would report the LLMSW and not the LMSW. There are three "SUD Program" codes, each with different time frames:

					Please note the qualifications and qualifying modifiers listed are a non-exhaustive list, use the staff level modifier that best represents the qualifications of the rendering staff. The Current Provider Qualifications column contains an exhaustive list.		
HCPCS & Revenue Codes	Service Description (Chapter 18 & PIHP Contract)	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units - Duplicate Threshold *D	Current Provider Qualifications	SFY 2022 Provider/Staff Qualifications	SFY 2022 Modifiers	SCA Cost Center
90832	Therapy (mental health) Child & Adult, Individual	Individual therapy, adult or child, 30 minutes of psychotherapy	Encounter	Child therapy: A physician, psychologist, licensed master's social worker (or limited-licensed master's social worker supervised by a licensed master's social worker), licensed marriage and family therapist or a licensed or limited-licensed professional counselor + one year of experience in examination, evaluation and treatment of minors and their families. Services to children ages 7 through 17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4 through 6 with SED must be provided by a CMHP trained in PECFAS. Services rendered to a young child, birth through age 3, must be provided by a CMHP trained in the Devereux Early Childhood Assessment (DECA). When providing family therapy using the trauma specific intervention, Child Parent Psychotherapy, for infants, toddlers, (birth through 47 months) and their family member(s) or other person(s) significant to the beneficiary (i.e., foster parent), mental health professional must minimally have endorsement as an Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred. Adult individual/group therapy: Mental Health Professional, including a limited-licensed master's social worker supervised by a licensed master's social worker.	Psychiatrist	AF - Specialty physician	Psychiatric Services - Med Clinic
					Physician	AG - Physician	Psychiatric Services - Med Clinic
					Psychologist	AH - Clinical Psychologist	Outpatient
					Master's social worker	HO - Master's Level	Outpatient
					Licensed professional counselor	HO - Master's Level	Outpatient
					Marriage and family therapist	HO - Master's Level	Outpatient
					Master's in Human Services Field	HO - Master's Level	Outpatient
					Bachelor's in Human Services Field - Child / CMHP Provider Only	HN - Bachelor's Level	Outpatient
					Registered Nurse	TD - Registered Nurse	Psychiatric Services - Med Clinic
					Psychologist	HP - Doctoral Level	Outpatient
90832	Substance Abuse: Outpatient Care	90832: Psychotherapy, 30 minutes with individual and/or family member	Encounter	For psychotherapy (90[6xx series codes): SATS Only: Master's prepared with appropriate licensure and working under appropriate supervision may provide services.	Psychiatrist	AF - Specialty physician	Psychiatric Services - Med Clinic
					Physician	AG - Physician	Psychiatric Services - Med Clinic
					Psychiatric mental health nurse practitioner	SA - PA, NP, CNS	Psychiatric Services - Med Clinic
					Clinical nurse specialist	SA - PA, NP, CNS	Psychiatric Services - Med Clinic
					Licensed physician's assistant	SA - PA, NP, CNS	Psychiatric Services - Med Clinic

Question	Answer
Do we send the encounter over under the CPRC or under the SATP supervisor? 	H0050 (15 mins) H2035 (hour) H2036 (per diem) All share same language about the non-clinical supports. When a service is a full hour (H2035) or a day (H2036), there's more time/room for peers/others to deliver non-clinical supports. For H0050, if a peer does assist with the non-clinical parts of a 15-minute brief service, it'd still be reported for the person who did the clinical part. It it's 100% non-clinical, then it's an H0038. It's non-clinical vs. clinical that's the key. The SATP would be reported if H0050 were used. If there's only a peer involved for those 15 mins, it's not H0050. It's H0038.
I have a provider who as a Master's in Art, and a CADC. Does the provider need to bill with the HO modifier? From what I'm seeing, a provider needs a MA in MH. That is listed in that qualifications chart under the QBHP and CMHP columns on the "Qualifications Crosswalk" tab. The "Job Title-Modifier Crosswalk" tab says HO can be used for "CADC – Master's", does it matter what the Master's degree is in. Can the provider who has a Master's in Art, and also a CADC use the HO Modifier, or should they use the HM modifier, or a different one? This is specifically for a SUD provider. I appreciate any feedback and clarification you have on the matter. Please let me know if you need additional information regarding the question.	In this case, since the master's degree is NOT related to MH, then they would use the correct modifier for the CADC. So, the HM modifier and not the HO.
How should providers bill in situations where the ASAM Continuum cannot be completed during the initial assessment appointment, and a second appointment has to be made to complete the ASAM Continuum? H0001 is allowable 4x per year, but is it allowable for the provider to bill H0001 (an encounter code, not unit based) for each session spent on the ASAM Continuum assessment? Thanks.	You are correct that the Duplicate Threshold (DT) is 4 per year. This means that the actuary will interpret each of the first 4 instances that H0001 is reported as a distinct and separate assessment. Think about the implications, then. Since it is encounter-based (and not time-unit based as you correctly observed/indicated), the assumption would be for the assessment to be billed once on the day it was completed. It becomes an encounter when it's completed and would be reported only once if it spills over into another session. It is allowable for you to bill this as two completed sessions (it is under the DT of 4). It would be

Question	Answer
	interpreted here that you completed an ASAM assessment and then completed another one. We would not interpret it as one uncompleted session and then another one on another day to finish the uncompleted one. Given that, the answer to your question is that the accurate way to report it is once and only once, and the completion of the 2nd appointment. It becomes an encounter when it is completed.
I have what I think is a simple question. When a dietician is billing the H0032 they would normally use the AE modifier however on the crosswalk the AE modifier is not an option. Would we be expected to downgrade the license to the HN/HO or can the AE modifier be added to the educational modifiers on the crosswalk?  	We will be adding the AE/Dietician to the H0032.
We were asked a question by one of our SUD providers regarding H0020. Since all of the codes have provider level modifiers, do you want the modifier on the encounter to be the modifier of the actual provider who dispensed the methadone (ie, RN, LPN)…or do you want the modifier of the NP or PA or Medical Director who ultimately has final decision on the dosing?	H0020 references the administration/provision of the methadone. Report the actual provision (RN, for example) and not Medical Director/decision-maker.
In looking at the Code Chart for 96127, it has Bachelor's in Human Services as a qualified staff; which could be licensed or unlicensed staff who are QIDP and CMHP.  However, under the H0031 Crosswalk, the 96127 does not include the Bachelor in Human Services. 	This is because the H0031 is available for the bachelor's level staff so the purpose of the crosswalk was to show that the codes available for master's and higher-level professionals that could no longer use the H0031. Per the code chart the bachelor's level in Human Services is allowable for the 96127.

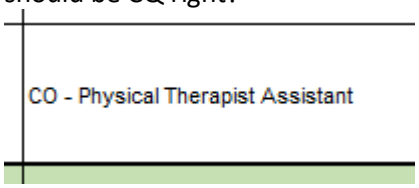
<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td>I would like to request that MDHHS explore updating the H0031 crosswalk to include Bachelor in Human Services (QIDP, CMHP). Many brief emotional/behavioral assessments can be and are completed by a staff with a Bachelor in Human Services (licensed and unlicensed) who is a QIDP or CMHP in an effort to link beneficiaries to services and supports that are medically necessary.</td><td></td></tr>
<tr><td>The MDHHS specifications require the H2030-Clubhouse services to be entered with provider level modifiers of the staff providing services.
The issue is that these Clubhouse uses the H2030 for the entire day regardless of who and what an individual is doing during the work order day. We will have multiple staff with varying levels of education working with any number of people at any given time so services are entered with a StaffNA user which has no educational level assigned. Trying to pull out who with what degree worked with which member at what time will be a difficult and time consuming.
We are asking if this really was meant to be required? Is there any other way we could report this?</td><td>We will be removing the provider level modifiers for H2030.</td></tr>
<tr><td>Should the 97154 & 97157 have the group modifier codes added to it in the chart?</td><td>We will add the U modifies to both 97154 and 97157.</td></tr>
<tr><td>We have an LLP that is on our ACT team. The provider code chart does not list the AH modifier for the H0039 ACT code. Will it be a problem with the data logic on the part of MDHHS if I report the AH modifier with code H0039-ACT?</td><td>We will add the AH to H0039.</td></tr>
<tr><td>With the current update to the Peer Specialist modifiers, I wanted to ensure that I am understanding the updates correctly.

WR: Non-Certified Peer Specialist
WS: Certified Peer Specialist/Certified Recovery Coach

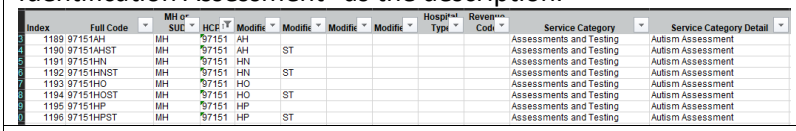
Prior to this update, non-certified Peers were not allowed to utilize the H0038 code and instead needed to utilize H2015. With the update to the modifiers, are non-certified Peers able to utilize H0038:WR, therefore rescinding the guidance the H2015 needs to be used?

For Certified Peers, they'll continue to use H0038:WS for both Peer Specialists and Recovery Coaches?</td><td>If the code, such as H2015, does not list the Peer's as providers then you would use the H0038. Would the non-certified Peer fall under the same category as the non-certified peer recovery coach? I am looping Phil in because I believe that yes the non-certified peers would use the H0038:WR. The certified peer specialist and certified peer recovery coaches would use the H0038:WS.

<table><tr><td>WR</td><td>Peer Recovery Coach - not MDHHS certified (MCBAP or C-CAR)</td></tr><tr><td>WS</td><td>Certified Peer Specialist/Peer Recovery Coach - MH/SUD - provided or assisted with covered service</td></tr></table></td></tr>
<tr><td>This question is regarding student interns.
Can you clarify how MDHHS is expecting to receive encounters where the student intern is rendering the service under the</td><td>Student Interns are not enrolled providers in CHAMPS. You would report under the supervisor</td></tr>
</table>

Question	Answer
supervision of a licensed provider? We want to be sure we are reporting those services correctly.	and use the supervisor's job title/education for the modifier. Medicaid policy has always indicated services performed by student interns must be billed under his/her supervising fully licensed provider. CHAMPS is only able to recognize and validate Medicaid enrolled providers. Claims and Health Plan Encounters submitted with unenrolled CHAMPS providers listed in either the Rendering Provider field, Supervising/Referring Provider field, or Attending provider (facility only claims) fields would reject. Since Student Interns are not enrolled within the CHAMPS system, they cannot be listed in any of these required provider fields.
Student interns have historically been reported under the supervisor for encounter reporting purposes. The Medicaid Provider Manual reference is copied below. If reporting under the supervisor, should the provider credential modifier reported be that of the supervisor? Per the Medicaid Provider Manual (page 528) – These temporary or educational limited licensed providers or student interns are not eligible to enroll or be directly reimbursed by Medicaid. Services should be billed to Medicaid under the National Provider Identifier (NPI) of the supervising provider.	That would be correct since the intern is not an enrolled provider. Medicaid policy has always indicated services performed by student interns must be billed under his/her supervising fully licensed provider. CHAMPS is only able to recognize and validate Medicaid enrolled providers. Claims and Health Plan Encounters submitted with unenrolled CHAMPS providers listed in either the Rendering Provider field, Supervising/Referring Provider field, or Attending provider (facility only claims) fields would reject. Since Student Interns are not enrolled within the CHAMPS system, they cannot be listed in any of these required provider fields.
I think in the code chart for 97530 for PT the following modifier should be CQ right?  	Yes, it should be CQ. We have updated the chart.
<u>First question:</u> *"We are still trying to determine the most appropriate code for the Functional Behavior Assessments since the H0031 is no longer allowed for staff with specific credentials. We had decided on 96112/96113 and now someone is telling us that there is an age specification on this. Do you know if these codes are only valid for children or if they can be used for adults as well?"* Q1: My research on codes 96112/96113 has not revealed to me any age restriction on the use of those codes. Are you aware of any age restriction?	Q1. We are not aware of any age restrictions for these codes; however, the 97151 is the correct FBA code to use. This code can be used for Autism and non-Autism. Q2. The 97151 is the correct FBA code to use. This code can be used for Autism and non-Autism.

Question	Answer
Q2: What is the best code to use when the provider is credentialed to perform an ABA assessment, but is not necessarily credentialed to perform H0031? <u>Second question:</u> *"The Mental Health system has built the capacity for I/DD Adult Behavioral Assessments by hiring/contracting with limited licensed psychologist who meets Michigan Medicaid credentialing requirements. The majority if not all Commercial and Medicare plans require fully licensed professionals which is causing issues with the codes we've identified (96112/96113) as replacement for H0031. A large portion of the I/DD population is covered by Medicare and/or Commercial plans. To continue to provide this service is the H0031 allowable or is the primary payer rejection for credentials an appropriate denial for billing Medicaid?"* I believe the concern/question here is that because Medicare (and other Third Party insurers) are rejecting based on credentials… can the CMHSP still then move forward with covering that service with Medicaid dollars (since Michigan Medicaid credentialing level is lower and allows it)? Or… can they NOT cover it with Medicaid "because Medicare has rejected it"? Q: Can we cover these ABA assessment services with Michigan Medicaid funding after receiving a Medicare (or other Third Party insurer) rejection for invalid credentials (due to the difference in CMS credentialing and Michigan Medicaid credentialing)?	This goes to primary payer rules. If a Medicaid beneficiary is dual enrolled, Medicaid becomes secondary (payer of last resort) and the other payer becomes primary…and their rules apply to all services. So, if Medicare requires a higher level of education for a provider, then those rules must be followed. If Medicare denies due to primary payer rules not being met, Medicaid cannot cover that service. While we appreciate the fact that they would like to use a provider with lesser credentials to increase access, that is not a reason for Medicaid to cover the service.
I am curious if a nurse practitioner does not have their psychiatric certification are they still able to bill E&M codes like an NP with the psychiatric certificate? What CPT codes would be off limits for a NP without the psychiatric certification, any?	Please look at this: <u>Service Description (michigan.gov)</u> There are specific services where the "psychiatric mental health nurse practitioner" is listed and others where the "nurse practitioner" is listed. For example: the 90791/90792 clearly states psychiatric mental health nurse practitioner and the 99202-99215 and other E&Ms all list nurse practitioner.
How many 9083x individual therapy encounter can be billed per day?	Per CHAMPS the MUE for 90837 is 3 per day. I am not sure which code you are needing but ran that one as an example.
Yesterday you stated that the U5 modifier needs to be added to 97151 for autism services eff 1/1/22. What about other codes that are used for both autism and non-autism services? Since H0031 was taken away, providers are using 96112/96113 and 96130/96131, 96130/96137 for some of the Autism assessments (ex - ADOS/ADIR).	The U5 is only to be used on the 97151 per the actuary and is effective 1/1/22 for all autism beneficiaries/programs.

Question	Answer
The latest code chart update is expanding the use of CPT code 97151 to non ABA services (#145 and #146). In discussion with our EHR vendor (PCE) on what this change means to the programming of our system, it has been requested to obtain clarification on the following.. Is state adding a new code to their Encounter Reporting Code Chart? Will the state be adding 8 more lines? For instance 97151:U5:AH 97151:U5:AH:ST, etc. Also, the Code Sets current 97151 has "ABA Behavior Identification Assessment" as the description.  Index | Full Code | MH or SUD | HCPCS | Modifier | Modifier | Modifier | Modifier | Hospital Type | Revenue Code | Service Category | Service Category Detail 1189 97151AH MH 97151 AH Assessments and Testing Autism Assessment 1190 97151AHST MH 97151 AH ST Assessments and Testing Autism Assessment 1191 97151HN MH 97151 HN Assessments and Testing Autism Assessment 1192 97151HNST MH 97151 HN ST Assessments and Testing Autism Assessment 1193 97151HO MH 97151 HO Assessments and Testing Autism Assessment 1194 97151HOST MH 97151 HO ST Assessments and Testing Autism Assessment 1195 97151HP MH 97151 HP Assessments and Testing Autism Assessment 1196 97151HPST MH 97151 HP ST Assessments and Testing Autism Assessment	The addition of the U5 modifier will create 8 new rows, including those with both the ST modifier and the U5 modifier. A picture of the 97151 code sets is included below for reference. 
If a Dr is licensed in Virginia, can they bill a telehealth visit for someone in Michigan?	No. This is not allowed. They need to be licensed in Michigan.
I want to revisit my ask back when we were struggling to find a replacement code for the H0031 change for 10/1/21. The only code that our clinical team found that fit the assessment that we provide is the 90791. I asked before about primary payer rules and you indicated that Medicaid was not following Medicare rules for eligible providers. Now because we are short (as well as everyone else) on LMSW, we have LPC and limited license completing these assessments, but we cannot bill Medicare. Would there be any allowance for still using Medicare funds without billing Medicare like we were allowed to do for audio only E/M because of COVID? I am certain we are not the only CMH in this situation and I feel like there was recently another directive rescinded because of an ask from multiple CMHs so I thought I would toss this one in the ring.	I provided the following statement after consulting with HASA for a similar question regarding 96112/96113 last week: If a Medicaid beneficiary is dual enrolled, Medicaid becomes secondary (payer of last resort) and the other payer becomes primary…and their rules apply to all services. So, if Medicare requires a higher level of education for a provider, then those rules must be followed. If Medicare denies due to primary payer rules not being met, Medicaid cannot cover that service. While we appreciate the fact that they would like to use a provider with lesser credentials to increase access, that is not a reason for Medicaid to cover the service.
We have some questions pertaining to CLS workers providing CLS H2015 services in certain types of settings. Our clinical leadership team asked that we seek clarification from MDHHS. 1. Is it allowable for individual CLS H2015 services to be provided to a consumer residing in a General AFC Home **in the actual General AFC setting**? 2. Is it allowable for individual CLS H2015 services to be provided to a consumer residing in a General AFC Home **outside of the actual General AFC setting**? 3. Is it allowable for individual CLS H2015 services to be provided to a consumer residing in a Specialized	1. Is it allowable for individual CLS H2015 services to be provided to a consumer residing in a General AFC Home **in the actual General AFC setting**? The General AFC POS is 33 and per the code chart and the appendix (language below) this is not allowed. 2. Is it allowable for individual CLS H2015 services to be provided to a consumer residing in a General AFC Home **outside of the actual General AFC setting**? Yes 3. Is it allowable for individual CLS H2015 services to be provided to a consumer

Question	Answer
Residential Home **in the actual Specialized Residential setting**? 4. Is it allowable for individual CLS H2015 services to be provided to a consumer residing in a Specialized Residential Home **outside of the actual Specialized Residential setting**? Multiple CMH/PIHP staff have reviewed the code chart & are interpreting it differently. Therefore, we thought we should ask just to be sure.	residing in a Specialized Residential Home **in the actual Specialized Residential setting**? The Specialized Res POS is 14 and per the code chart and the appendix (language below) this is not allowed. 4. Is it allowable for individual CLS H2015 services to be provided to a consumer residing in a Specialized Residential Home **outside of the actual Specialized Residential setting**? Yes **3. H2015 - as used to provide staff support by CMH staff - generally an intermittent activity** This use of H2015 that occurs at a CMH program/clinic generally falls into several alternatives: a) CLS as provided by peers who are not yet certified b) Provision of some specialized CLS activity -- often done in a group at the CMH site c) Outreach activities Use of UN, UP, UQ, UR, and US modifiers When the CLS aide is typically providing CLS to two or more consumers at the same time in the community setting (i.e., group activities) the corresponding U modifier should be used. Code: H2015 reported in 15-minute increments Place of Service Code: Codes expect to see in most instances: 11- office, when done at the CMH site 04 - homeless shelters - when CLS staff reach out to these shelters to assist persons New code - in the community 12 - home Locations EXCLUDED: • Location 14 -- licensed residential • Location 33 - general AFC • Nursing homes (31,32) This is primarily a staffing cost but may include facility costs if the CLS activity is being provided at a CMH office. Cost includes staff costs (including supervisory staff), facility (lease/mortgage, utilities, maintenance), equipment, travel, supplies and materials , and provider administration
Because H2000 is committee based would it be possible to add to the list of allowed provider credential modifiers to include individuals that are part of the committee that may be different than those listed, such as other licensed clinical staff. Some committees have chairpersons that are not a psychologist or psychiatrist even though the psychologist and psychiatrist are members of the committee.	We have added the BCBA and LBA to the provider modifiers for H2000.
Good afternoon – because the provider credentials for H2000:TS are different that H2000, I think it would be beneficial to add H2000:TS to the Code Chart tab. If a Certificate of a BCBA can provide H2000:TS then so can the LBA and ALBA license. It would be more clear to have these defined within the code chart. Thoughts?	We have created a separate row for H2000 TS.
Has anyone asked you to remove the Provider Level modifiers for Peer Operated Drop In / H0023 as well. Drop In encounters are a result of an in/out attendance log at the Drop In Centers. Peers who (drop-in) are not necessarily receiving one-on-one service provision by a Peer Provider. Most drop ins are just that a client drops in (signs in and associates with other drop in clients, signs out and leaves) Is this something that we need to discuss?	We have removed the provider level modifiers for H0023.
Our CMH is discussing what codes should be used for a Crisis Intervention Contact Note and Inpatient Screening. The obvious	We plan to bring this question to our next EDIT meeting on January 20, 2022.

Question	Answer
first thought was that a Crisis Intervention Contact Note would be a H2011 and an Inpatient Screening would be a T1023. However, we also remember there has been previous discussions about H0036, H0038, H0039, T1017, and possibly other codes being used because they are either bundled services or should be used instead of the H2011 and T1023. It would be nice to make this less confusing and always just report the Crisis Intervention Contact Note as a H2011 and an Inpatient Screening as a T1023, but we want to be consistent with the rest of the CMHs and MDHHS. Can you please provide some guidance on this?	
Can you clarify the distinction between H2021 and H2022? H2021 is a 15 minute code and H2022 is a per diem but from the description on the code chart it is difficult to tell when to use each.	There was an error in the code chart that had the H2021 listed as both a MH and a SEDW covered service. So, the line for H2021 that was in green was deleted. SEDW beneficiaries use the H2022 per diem code and all others use the H2021 15-minute code.